FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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BUREAU OF FACILITY STANDARDS
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July 7, 2006

Sue Broetje, Acting Administrator
Idaho State School & Hospital
3100 11th Avenue North
Nampa, ID 83687

Dear Ms. Broetje:

Based on the Medicaid/Licensure survey completed at Idaho State School and Hospital (ISSH) on June 19, 2006, by our staff, we have determined the immediate jeopardy at the facility has been abated. However, the following four (4) Medicaid ICF/MR Conditions of Participation were determined to be out of compliance:

Condition of Participation on Governing Body and Management (42 CFR 483.410),
Condition of Participation on Client Protections (42 CFR 483.420),
Condition of Participation on Active Treatment Services (42 CFR 483.440), and
Condition of Participation on Client Behavior and Facility Practices (42 CFR 483.450).

To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet substantially limit the capacity of ISSH to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

ISSH's Medicaid Provider Agreement expired June 30, 2006, however, it was subsequently extended from July 1 – August 31, 2006. Based on the survey findings, ISSH's provider agreement, which will expire at the end of August, will not be renewed. Medicaid payment will cease effective September 1, 2006. You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance. **Such corrections must be achieved and compliance verified, by this office, before August 31, 2006. To allow time for a**

revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than August 18, 2006.

The following is an explanation of a credible allegation.

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and,
- That indicates resolution of the problems.

In order to resolve the deficiencies, the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, a Provisional Intermediate Care Facility for Persons with Mental Retardation license is being issued to ISSH, effective June 20, 2006 – September 30, 2006. The conditions of the Provisional License remain as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Please be advised that you have the right to appeal the nonrenewal action as described in 42 CFR Sub-part B, Sections 431.151 through 431.154. The appeal procedures are described in the Department's Contested Case Rules (IDAPA

16.05.03.300). Be advised, also, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the provisional license. The first step in the appeal process is an administrative review. *To be entitled to an administrative review, your request must be submitted in writing within twenty-eight (28) days after the date of this letter, which is* ***August 4, 2006.*** A request for administrative review must be signed by the facility's administrator, identify the challenged decision(s), and state specifically the grounds for your contention that the decision was in error. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 364-5747
fax: (208) 364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decisions become final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

Sharon Duncan

SHARON DUNCAN, Chief
Bureau of Long Term Care

Debra Ransom

DEBRA RANSOM, Chief
Bureau of Facility Standards

SC/nm
Enclosures

c: Randy May, Deputy Administrator, Division of Medicaid
Willard Abbott, Deputy Attorney General
Sylvia Creswell, NonLTC Supervisor
Lynn Denne, RMS Manager, Region III

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

Sue Broetje – Administrative Director
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August 17, 2006

Debbie Ransom, R.N. R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Please consider this letter and the information contained within to be a credible allegation that the Idaho State School and Hospital has implemented system changes and provided training which address the condition of participation concerns outlined in the recertification survey which was completed 6/19/2006.

The facility made the following changes to improve the services and practices at the facility:

- Changes were made in supervision of the client units to provide for more active monitoring, training, and more expedient corrective action when necessary. While these changes are temporary, they will remain in place until a permanent structure which supports continued compliance and improvement in services.
- ISSH Policy R.L. #22 was revised to provide improved definition of PICA and the actions to be implemented for the different types. Changes were also made to the definition of leave without permission. The term was changed to Elopement to differentiate when a client left unbeknownst to staff and when the client attempted to leave but was still under the sight or supervision of staff. Clarification was also made on when an elopement could be addressed through the Significant Event Reporting system of review and when it needed to move to the Neglect Investigation process.
- The Psychotropic Drug Review Form was revised to ensure a formal review of medication criteria at each review and to provide a place for documentation of medication changes made or not made and the team's rationale. In addition, teams were trained to ensure that the environmental/behavioral changes since the last review are carefully reviewed and included in this section of the PDR form. QMRPs and Clinicians were also retrained on the expectation to review the client status monthly and make appropriate referrals when criteria for medication changes are met.
- Clinicians reviewed all BSPs, and revised as needed to ensure the accuracy of medication criteria, the clarity of instructions to staff, and that the status section is accurate and current to the last update.
- Client assessments have been updated as needed to ensure they are current.

- Additional training was provided to unit staff on consistent implementation of formal training programs as well as informal interventions to improve client independence.
- Active treatment schedules were modified, as needed, to provide better direction to staff and to assure that all programs, both formal and informal are run at appropriate times of the day.
- The Behavior Reporting Form was modified to require more specific and detailed data. The format for the narrative ABC recording was improved so that staff includes sufficient detail in each of the three areas, antecedent, behavior, and consequence. The unit supervisors review the form for completion daily and the assigned clinicians review for accuracy and detail weekly. Continued training to direct care staff is provided as needed during weekly behavior meetings.
- Data collection was reviewed to determine its suitability to assess client progress toward objectives and to make medication changes. Episode recording and time samples have been discontinued with exceptions made only with approval by the Clinical Director.
- ISSH Policy R.L. #1 was modified to provide clearer and more consistent direction on requirements for the use of behavioral restraint.
- The facility HIS manual was modified to ensure it is consistent with R.L. #1, the ISSH restraint policy.
- ISSH Policy R.L. #3 was modified to include all current facility approved interventions.
- ISSH Policy Med. #34 was developed to provide clearer and more consistent direction on requirements for the use of medical restraint.
- Modifications were made to the abuse allegation report reviews and additional information is being requested if the reviews lack sufficient detail.
- QMRPs were retrained to ensure that programs changes are initiated when clients have reached criterion, failed to progress after reasonable attempts or shown regression. The QMRP manual clearly outlines the criteria to use as a "flag".
- The facility's Performance Improvement Department and the new program directors have done extensive daily reviews in the above noted areas to ensure that the changes were made and that improvements are being sustained. Additionally, they provide Just in Time training as needed on an ongoing basis and alert the Q's of any concerns so corrective action can be initiated.

While the facility has additional plans than we are confident will result in even further improvements to our services, we feel the above actions have placed us in substantial compliance with the Conditions of Participation that were not met. All changes were in place and applicable staff trained by August 17, 2006.

Sincerely,

SBroetje

Susan Broetje
Administrative Director

Attachments: R.L. #1
R.L. #3
R.L. #22
R.L. #35
MED #34

Department of Health and Welfare
Idaho State School & Hospital
Nampa, Idaho

Operating Policy and Procedures

Subject: Behavioral Restraint: Programmatic and Emergency Use		**Policy:** R.L. #1 **Page:** 1 of 12
Effective Date: August 9, 2006	**Supersedes:** R.L. #1 Dated 08/18/00	**Approved By:** **Date:** 8/9/06

I. PURPOSE:

The purpose of this policy is to provide guidelines and procedures for the safe use of restraint to ensure welfare and human rights of individuals are adequately protected. The intent is:

1. Restraint is an integral part of the individual's program plan.
2. The plan leads to less restrictive management or the elimination of the behavior or symptoms for which the restraint is applied.
3. To set guidelines for the use of restraints that are not part of the plan (emergency restraint).

II. PHILOSOPHY:

The use of restraint is highly intrusive, potentially dangerous, and undignified. Restraint is a last resort procedure, used only when an individual is in danger of hurting themselves or others. As with all intrusive interventions, restraint is used only when less intrusive, positive procedures have proven to be unsuccessful. The Idaho State School & Hospital (ISSH) is committed to using de-escalation techniques and assessment based interventions to address restraint use. Direct service staff is trained in the safe application of restraint and in the use of crisis de-escalation techniques. ISSH recognizes the importance of reviewing restraint usage at different levels in the organization to minimize its use.

The intent of the Person Centered Plan (PCP) is to eliminate or manage the behavior for which the restraint is applied. Restraint is not to be used for disciplinary purposes, for the convenience of staff, or as a substitute for active treatment. Every effort will be made to treat individuals with dignity and to provide safe and effective restraint practices. Restraint practices are designed to cause the least amount of physical injury and discomfort. Standing (House Rules) or as needed programs to control inappropriate behavior are not permitted.

ISSH takes the position that mechanical restraint is not necessarily more intrusive than the use of psychotropic medication to manage dangerous behavior (chemical restraint). Individuals have very different histories, medical conditions, and often present with complex behavioral and psychiatric needs.

When physical restraint is not sufficient or contraindicated the selection of a mechanical device or use of medication must take many factors into consideration. Therefore, the facility takes the stance that there is no set hierarchy of intrusiveness. The most therapeutic course is to select the type of restraint, based on assessment, which best meets the safety and psychological needs of the client.

There is increasing recognition that individuals with developmental disabilities experience the full range of psychiatric disorders. Evidence indicates that psychiatric disorders may contribute to behavioral disturbance and that manifestations of a psychiatric disorder are atypical when compared to individuals without developmental disabilities.

Thus the designation of psychotropic medication, used intermittently (PRN usage), as "*chemical restraint*" is not always accurate. While the use of PRN medication for challenging behavior unrelated to a psychiatric disorder can be considered as chemical restraint, its intermittent use can also be used to treat acute or episodic symptoms related to a mental illness. In some cases, PRN use of psychotropic medication as part of an approved program may be preferable to increasing the regularly scheduled psychotropic medication prescribed by a psychiatrist. At ISSH the use of programmatic PRN medication to treat episodic symptoms of mental illness is not considered a restraint, even though it is labeled as chemical restraint in this policy. When programmatic PRN medication is used to treat psychiatric symptoms, this use is made clear in the program.

Use of a regularly scheduled psychotropic medication, prescribed by a psychiatrist for a psychiatric disorder or for a behavior based on a pharmacological hypothesis, is considered restrictive but is not considered restraint. Such use is covered in Medical Policy #33 -- Psychoactive Drug Usage.

III. GENERAL REQUIREMENTS FOR USE OF BEHAVIORAL RESTRAINT

A. General Conditions of use:

Physical and mechanical restraint is only permitted to protect the health and welfare of an individual or others.

Physical and mechanical restraint is only used for the specific type of behavior or severity of behavior that is specified in the BSP or other program in the PCP. The BSP/PCP must specify the least intrusive form of restraint likely to be effective. That is, a specific level of restraint is selected to safely maintain an individual's safety. Graduated physical restraint, as taught in HIS, is used only up to the level specified in the PCP, except in an emergency.

B. Approved Restraints:

The physical restraints approved for use are those specified in HIS. These include the transport, stand, sit, and prone. See the facility's HIS manual for details. Modification of a restraint method requires a recommendation by the Training Department's HIS instructor and approval by the Clinical Director or Facility Administrator.

The use of metal handcuffs is prohibited. Any device with a hood or that covers the nose or mouth, is not permitted.

C. Training:

Staff is prohibited from using restraint of any type until trained. Training in the facility's HIS system is required prior to using physical restraint. The use of mechanical restraint also requires training by the team on the specific mechanical device to be used. In addition, staff must be trained in HIS approved verbal de-escalation techniques. HIS recertification is completed annually.

D. Initiation of Restraint:

1. *Physical restraint:* Any trained program staff can make the decision to initiate the use of HIS methods when the physical restraint is part of an approved program in the PCP and in emergency situations. Programmatic restraint is always initiated as directed in the BSP. Emergency use of physical restraint is covered in Section VI -- Emergency Use of Behavioral Restraint.

2. *Mechanical restraint*: The DDT makes the decision to initiate restraint as part of an approved program based on criteria specified in the BSP. Emergency use of mechanical restraint is covered in Section VI -- Emergency Use of Behavioral Restraint.

3. *Chemical restraint*: Nursing can administer a chemical restraint when:
   a. Criteria within the program plan are met;
   b. The administration of chemical restraint is approved by an authorized person; and
   c. A physicians order is obtained.

   Emergency use of chemical restraint is covered in Section VI – Emergency Use of Behavioral Restraint.

E. Monitoring and Duration of Restraint -- Physical and mechanical:

1. Staff must maintain visual contact of the client during restraint unless directed otherwise by the BSP.

2. Staff must check all individuals in restraint at intervals of not less than 30 minutes. This check should include ensuring proper fit of mechanical devices and proper body position for physical restraint. Adjustment must be made as needed to decrease potential for discomfort or injury. At no time should a visual check exceed 30 minutes. These safety checks are documented on the Restraint Data Sheet by the staff involved (See Attachment A).

3. When a restraint lasts 60 minutes and the release criteria have not been met:
   a. Nursing is immediately notified to complete an assessment (which might include vital signs) as indicated by the situation.
   b. After Nursing is notified, the supervisor or charge person immediately notifies the QMRP, Clinician, or RN/AOD.
   c. The QMRP, Clinician, RN or RNAOD makes a determination whether or not the restraint should end or continue. This determination is based on the results of the nursing review, staff report, and a direct observation of the client whenever possible.

4. After 90 consecutive minutes of restraint, the QMRP, Clinician, RN or RN/AOD must be contacted again for an additional assessment. Once again they will make a determination whether or not restraint can continue.

5. Physical and mechanical restraints that restrict the motion of a limb or joint require that an attempt be made to release the client every two hours for not less than 10 minutes and provide the opportunity for motion and exercise.
   a. When the client is released from restraint (or an attempt is made) and the client then puts her/himself or others at risk, restraint can be re-initiated.
   b. When restraint is re-initiated, the restraint is recorded as a new restraint, on a new line, with a new start time.
   c. When the client is not released for the full 10 minutes due to the need to protect the client or others, the reason should be documented in the comments section.

6. Mechanical restraints that do not restrict the movement of a joint or limb do not require removal every two hours. Helmets and mitts most often do not restrict movement and are, therefore, exempted from this rule. Mitts must not restrict the free movement of the individual's fingers. If they do, then they must be removed every two hours. Thirty-minute checks are still completed for restraints that are not removed, including those worn at night.

F. Monitoring and Duration of Restraint -- Chemical:

1. When the physician orders a chemical restraint, instructions for monitoring the individual shall be part of the physician's order.

2. Following administration of a chemical restraint, staff must report to Nursing immediately if observe any of the following: blue fingertips; loss of color in nail beds; cold extremities; any change in the level of consciousness.

3. The nurse will assess the client and document the effectiveness of the chemical restraint intervention for the targeted behavior not more than one hour after medication administration.

G. Documentation:

1. All physical restraints, mechanical restraints, and chemical restraints, regardless of duration, are recorded on the Restraint Data Sheet.

2. The date, the time the restraint began, and the time the restraint ended are recorded on the Restraint Data Sheet.

3. Record the type of restraint.
   a. Identify and mark whether the restraint is an emergency or programmatic; behavioral or medical. Mark only one of four choices:
      1. Emergency-Behavioral;
      2. Emergency-Medical;
      3. Programmatic-Behavioral; or
      4. Programmatic-Medical.

   b. Next mark the box indicating the form of restraint:
      1. Transport
      2. Stand
      3. Sit
      4. Prone
      5. Mechanical
      6. Chemical

4. Each 30-minute check made during physical and mechanical restraint is recorded with a hash mark.

5. All releases from restraint for motion and exercise are recorded under the heading, *2-Hr. Rule.*

a. When restraint is re-initiated because the individual is putting him/herself or others at risk, a new entry is made with a new start time. NOTE: All clients must be given this opportunity at least every two hours.

6. The staff member filling out the form prints their name and shift.

7. The reason for the restraint is recorded. Generally, the reason for restraint is the target behavior that put the client or others at risk of harm.

8. The Supervisor (DDS) or charge person is responsible for ensuring restraint documentation is accurate at the end of the shift.

IV. PROGRAMMATIC USE OF BEHAVIORAL RESTRAINT

A. Conditions for including restraint in the PCP:

Restraint may be used as part of an approved written program plan intended to reduce challenging behavior (See R.L. #3 -- Guidelines for Behavioral Intervention). Programmatic restraint is added to the PCP/BSP, given a history of dangerous behavior, and

1. When programmatic supports in the client's BSP have been demonstrated to be ineffective or contraindicated.

2. When the behavior is anticipated to pose a serious risk to self or others but there is not sufficient time to safely implement less intrusive supports. In such cases, programmatic restraint is used in conjunction with positive supports. If restraint is added prior to demonstrating the ineffectiveness of less intrusive measures, additional assessment and positive supports must be implemented concurrently or shortly afterwards.

3. When restraint can be reasonably anticipated to recur or when emergency restraint has occurred more than twice in two months.

B. Approval process for restraint as a component of the BSP/PCP:

1. Approval of programmatic restraint is a 4-step process and cannot be implemented unless the following four steps are completed:
   a. The Interdisciplinary Team decides to pursue the use of restraint and a program is written.
   b. The program is approved by the Human Rights Committee.
   c. Informed consent is obtained from the parent or guardian (See R.L. #12 -- Informed Consent).
   d. Staff is trained in the BSP and the proper application of the restraint.

2. When emergency restraint has occurred 2 times in 2 months or is anticipated to be used again, the Team may obtain temporary approval.
   a. Approval is obtained from the Clinical Director (or designee) and the HRC Chairperson.
   b. Telephone consent is obtained from the parent or guardian for a written program that includes the use of restraint. The maximum duration of this consent is 60 days.
   c. An attachment to an existing BSP detailing the use of restraint and any new procedures is acceptable. The attachment should be filed with the current BSP and the telephone consent.
   d. Staff is trained in the program and the proper application of restraint.
   e. The Team follows the four steps outlined above which result in a full HRC review and a written informed consent.

C. Components of the BSP:

A BSP submitted to HRC must either include or have accompanying documentation of a functional assessment of the target behaviors leading to restraint and a rationale for the proposed restraint.

1. The BSP itself must include, at a minimum, the following:
   a. Operational definitions of the target behaviors that initiate restraint;
   b. Adaptive or replacement behavior directed towards reduction of those behaviors leading to restraint;
   c. Specification of the types of restraint to be used. The approved restraint must be at the level required to maintain client safety.
   d. Clearly defined criteria for releasing an individual from restraint. These criteria are individualized and defined in the BSP.
   e. A description of the type and frequency of data to be collected.
   f. A plan to reduce restraint or, at a minimum, the identification of reasonable criteria for the development of a plan to reduce restraints.

D. Mechanical restraint:

In addition to the above information, mechanical restraint requires the following be incorporated into the BSP/PCP:

1. Photographs of the mechanical device, directions on the application of the restraint, and safety guidelines.
2. Instructions on the frequency of visual checks while in mechanical restraint (not to exceed 30 minutes).
3. Instructions to release the client from a restraint (restricting range of motion of a limb or joint) that lasts two consecutive hours and to provide the opportunity for motion and exercise.

V. EMERGENCY USE OF BEHAVIORAL RESTRAINT

There may be occasions when the team cannot anticipate the need for a restraint. If a situation arises in which a client's behavior puts him/herself or others in imminent risk of injury, the use of emergency restraint may be necessary. The use of emergency restraint is an intervention of last resort; less intrusive measures should always be tried first. Emergency restraint is only used after positive, less intrusive methods have proven ineffective and a clear risk of harm exists.

A. When emergency restraint is necessary, the use of physical restraint is generally used prior to the use of mechanical or chemical restraint. Only after it is decided that the use of physical restraint is not effective in preventing a risk of injury, should mechanical or chemical restraint be considered. The selection of mechanical or chemical restraint as the next step depends on many factors such as the client's history, psychological response to restraint, and the risk of injury with different restraint types.

B. **Physical restraint:**
Staff is limited to the use of an ISSH approved restraint system (HIS). Any trained staff person can initiate and apply emergency physical (manual) restraint for non-medical reasons. When physical restraint is not effective, the QMRP, Clinician, RN, or RNAOD must be contacted for further direction as soon as possible after the application of emergency physical restraint.

C. **Emergency mechanical restraint**:
Requires approval by the QMRP, Clinician, Clinical Director or RN/AOD; either in person or by phone. The use of another individual's restraint device is prohibited.

D. **Chemical Restraint** requires a physicians order.

1. DDS, charge person, or DDT notifies Nursing of the situation. Nursing assesses the individual and follows up on any medical issues.

2. DDS, charge person, or DDT contacts QMRP, Clinician, RN, or RN/AOD for approval; either in person or by phone.

3. Once approval has been obtained from an authorized person, the nurse calls the physician. A physician's order is necessary to use a chemical restraint. The physician's order must include the medication to be used and dosage to be given. The order will be co-signed within 72 hours if obtained by phone.

4. Instructions for monitoring the individual shall be part of the physician's order.

5. The LPN will document the use of the medication in the client services record.

6. DDTs will document emergency use of the chemical restraint on the BRF. An ABC narrative will be completed detailing the circumstances that lead to the target behavior requiring chemical restraint.

7. Nursing will notify the guardian of the administration of the emergency chemical restraint, as indicated by the guardian on the Guardian/Parent Notification Information Form #4102, located in the client record.
NOTE: The documentation requirements of this section do not apply to the use of a medication when it is part of an approved BSP.

E. **Release Criteria for Emergency physical and mechanical restraint:**
It is important that restraint end as soon as possible for the safety of the individual. Individuals vary; if an individual continues talking, making sounds, or even struggling, it does not necessarily indicate that restraint should continue. The HIS system directs staff in methods to determine if an individual is ready for release from the restraint.

It shall be the responsibility of the Interdisciplinary Team to develop a comprehensive program for any behavior that prompts the use of emergency physical restraint, emergency mechanical restraint, or emergency use of psychotropic medication more than two times in a two month period. However, a program is not required when the team determines and documents in the individual's program record that the precipitating conditions were transitory, not likely to be repeated, and that a behavior modification program is not appropriate as a solution to the problem (e.g., the individual was discovered to have severe pain, sickness or condition not detected immediately that led to severe behavior outbursts).

VI. REVIEW PROCESS

Review of restraint occurs on multiple levels.

1. On an ongoing basis the team will review restraints and their justification. Restraints are monitored weekly at team meetings. At least monthly, the QMRP will review restraint trends. The Team has restraint data for each client shift. The AA1 compiles this data monthly.

2. The Human Rights Committee will review individual programs using restraint at least annually. For those clients whose data does not show a reduction in the frequency of restraint, HRC will establish more frequent review intervals as it deems necessary.

3. The Clinical Director will review facility and building trends monthly.
   a. Each month the Clinical Director provides the QMRP graphs showing building trends in restraint and injuries due to restraint.
   b. Clinical Services will monitor restraint frequencies for clients identified to have high restraint frequencies. Clinical Services will notify the QMRP of individuals showing increasing trends and, as necessary, request information about causes and interventions currently in place.

4. The Clinical Director will ensure compilation of a quarterly report showing trends in total facility restraints, trends by living areas, and client injuries due to restraints. This quarterly data will be reported to each QMRP, the Director of Nursing, and the Administrative Director.

VII. DEFINITIONS:

A. Attachment A -- Restraint Data Sheet:
The Restraint Data Sheet is found on the Behavior Reporting Form (BRF), which also includes data on the frequency of target behaviors in the Behavior Support Program (BSP). Frequency counts are kept for target behaviors whether or not they result in restraint. Narrative recording of antecedent and consequent events is also part of the BRF. When a target behavior results in restraint, the frequency is noted, a narrative is completed and then the Restraint Data Sheet is completed.

B. Behavioral Restraint:
Behavioral Restraint is used only to prevent an individual from harming her/him self or others. It includes physical, mechanical, and chemical restraint. Behavioral restraint is used for non-medical reasons; the use of restraint for medical reasons is covered in Medical Policy #34 -- Medical Restraint. Behavioral restraint may be used either programmatically or in an emergency.

C. Chemical Restraint:
Chemical Restraint is the *emergency* or *programmatic* use of a single stat dose of psychotropic medication when the person's behavior is uncontrollable by other less intrusive methods and is used only if the behavior is dangerous to self or others or other methods are contraindicated. The periodic use of psychotropic medication is often referred to as a PRN and can be used to treat acute or episodic behavior or psychiatric symptoms.

1. **Psychotropic Medication** is any drug prescribed to stabilize or improve mood, mental status or behavior.

Psychotropic medication prescribed on a routine basis by a psychiatrist, i.e., not on a PRN basis, and that is used as an integral part of an individual's PCP is restrictive but is not considered a restraint. The use of regularly scheduled psychotropic medication is detailed in Medical Policy #33 -- Psychoactive Drug Usage.

D. Emergency Restraint:

Emergency Restraint is the unplanned or unanticipated use of restraint for problem behavior. Emergency restraint is not programmatic; that is, it is not part of an approved program. Emergency restraint may be used for both behavioral and medical reasons (Emergency Medical Restraint is covered in Medical Policy #34). Emergency restraint includes physical restraint, mechanical restraint, and chemical restraint.

E. Medical Restraint:

Medical Restraint is defined as a restraint ordered by a physician or dentist to facilitate the safe conduct of a medical treatment or to protect an individual from injury following a medical or dental procedure. Medical restraint may be in physical, mechanical or chemical form (See Medical Policy #34 -- Medical Restraint).

F. Mechanical Restraint:

Mechanical Restraint is the use of a device that cannot be easily removed and that restricts the free movement of, normal function of, or normal access to a part of a person's body. It is used when a client cannot be controlled/contained with physical restraint and when physical restraint is contraindicated. Examples include, but are not limited to, mitts, leather wrist or ankle cuffs, and helmets. A device such as a helmet may not restrict the free movement of part of a person's body but it qualifies as a restraint because it limits normal access to a part of the individual's body.

G. Non-contingent Mechanical Restraint:

Non-contingent Mechanical Restraint refers to behavioral restraint that is used in a preventative way; it is not applied contingent upon the behavior putting someone at risk. Instead, restraint is applied prior to the occurrence of a harmful behavior. For example, a person might wear a device to prevent a behavior that is very serious and cannot be prevented in a timely way. Non-contingent restraint requires a plan to reduce the use of the restraint.

H. Physical Restraint:

Physical Restraint includes any body to body contact that restricts the free movement of, normal functions of, or normal access to an individual's body parts. The Human Interaction System (HIS) specifies the physical restraints permitted at ISSH.

I. **Programmatic Restraint:**
Programmatic Restraint is the planned use of restraint as a component of the individual's PCP. The inclusion of restraint in the individual's PCP requires an approved written program that details the use of restraint. Programmatic restraint may be used for a behavioral or medical reason (See Medical Policy #34 -- Medical Restraint). Physical, mechanical, and chemical restraint can all be used programmatically.

J. **Exclusions**: In general, techniques that limit a client's movement when the client resists, are considered restraint. Excluded from the definition of "Restraint" are:

1. **Physical guidance and prompting techniques** of brief duration. Prompting is a teaching technique and is not designed to overpower a client should she/he resist. The purpose of physical prompting is to teach a new skill by momentarily increasing a desirable behavior so that it can be reinforced. Restraint is not intended to increase an adaptive skill.
   a. **Escort:** The use of a hands-on physical support to assist or stabilize an individual. The escort is detailed in the HIS manual.
   b. **Mechanical devices** to support proper body positioning or alignment.

IX. ATTACHMENTS:

Attachment A – Restraint Data Sheet and Behavior Reporting Form

References: ICF/MR Regulations – W285-288, W290, W295, W297; ISSH Policy Medical #33 – Psychoactive Drug Usage; Medical Policy #34 – Medical Restraint; R.L. #3 – Guidelines for Behavioral Intervention; R.L. #12 – Informed Consent; Guardian/Parent Notification Information Form #4102.

REVIEW: Clinical Director
Required Reviews/Approvals: Policy Review Committee; Administrative Director
Review Date: 7/06 **Next Review Date:** 7/09
Originator/Date: G. Tidwell, 10/05

ISSH Form #7020

Attachment A – R.L. #1

Restraint Data Sheet

CLIENT'S FULL NAME: **LIVING AREA/GROUP #:**

Instructions: (1) write, time restraint began (time in) and ended (time out). Indicate am/pm. (2) In the first shaded area determine if the restraint is an emergency or programmatic restraint. Then record with a check mark whether the restraint is Behavioral or medical. (3) Check the form of the restraint: Stand, Transport (Tranp), Sit, Prone, Mechanical (Mec), or Chemical. (4) Indicate with a check mark all 30 minute safety checks. (5) If a restraint lasts 2 hrs, check if the opportunity was given for motion and exercise (Exer) (6) Sign your name and indicate your shift (D/S/N). (7) Briefly describe the reason for the restraint (, AS, SIB, dental, lab, etc.) and (7) Nurse indicates skin check

Time in restraint			Emergency		Program		Form of Restraint						30 Minute Checks				2 hr. Rule			
#	Time In	Time Out	Beh	Med	Beh	Med	Stand	Trans	Sit	Prone	Mech	Chem					Exer	Staff Name/Shift	restraint reason	Nurse skin check
1																				
2																				
3																				
4																				

Comments:

PROGRAM: Check box when restraint is part of approved program.
BEHAVORAL: (Beh) Behavioral restraint is for non-medical reason
MECHANICAL: (Mech) List type of restraint device (e.g. leather cuffs, splints, helmet B, mitts,
CHEMICAL: (Chem.) Check the chem box when a physician ordered medication is given.

EMERGENCY: A restraint not in the client's BSP/PCP
MEDICAL (Med): Restraint during or following medical treatment

Rev. 7/11/06 – G.Tidwell

Updated: 8/9/2006

Client:	24 Hour BEHAVIORAL REPORTING FORM																						Date:
Staff	**AM**						**PM**																**NOC**
	Antecedent–Before behav						**BEHAVIOR**								**Consequence**-after behav						OTHER INFORMATION					
Time occurred																		*Restraint Y=Yes N=No If yes fill out back	*Client injured yes or No	*immediate protection from harm Y=yes N=no	*Client Victim	*Staff Victim	*Staff initials	Comments

PHYSICAL ASSAULT

Action in which either the intent or the likely outcome is to cause bodily injury* to another person. Note, there does not actually have to be an injury, but the action is such that any reasonable person would determine that either pain or a potential injury could occur. Examples include the following: Pushing, hitting, scratching, biting, kicking, pinching, head-butting, hair pulling, throwing objects at others with actual contact, choking, intentional throwing, smearing, etc. of body fluids on another person

ATTEMPTED PHYSICAL ASSAULT

Action, which, if completed, would have likely, caused bodily injury to another person. Examples are the same as for actual physical assault, but the attempt was not successful, either due to staff intervention or other factors.

VERBAL THREAT

A verbal statement or gesture which a reasonable person would interpret as a threat. Examples include: I'm going to kill you, I'm going to cut out your eyes / eye, you better watch your back, making a gesture of slicing across the throat, any type of overt sexual threat.

OFFENSIVE LANGUAGE

Swearing or outburst made in anger or with the implied purpose to insult or irritate. Verbalizations which lead to an overall negative atmosphere, but would not make a reasonable person fearful of his/her health or safety. Examples include: I hate you, F___ you, you are a b_____, Screaming something like "Get out of my face,"Calling names (bitch, retard, jerk, etc.)

Other Targets here:

Department of Health and Welfare
Idaho State School and Hospital
Nampa, Idaho

Operating Policy and Procedures

Subject: Significant Event Reporting		**ISSH Policy: R.L. # 22** Page 1 of 7
Effective date: August 11, 2006	**Supersedes:** R.L. #22 dated 06/01/06	**Approved by:** SBroetje **Date:** 8/14/06

I. PURPOSE:

This policy:

- outlines the steps for documenting injuries and other significant events that occur to individuals who reside at Idaho State School and Hospital (ISSH).
- provides a system for developing procedures to reduce these types of incidents.
- provides a system of aggressive team action and administrative review of significant events. It is our goal to reduce and/or prevent psychological and physical harm to clients.

II. POLICY:

It is the responsibility of ISSH staff to promote an environment which contains reasonable risks and adequate protections to ensure optimum client safety. Staff will document incidents of harm and potential for harm as defined in Section III; treatment team staff will review and develop improved operating procedures; and administrative staff will review, evaluate and make recommendations for improved practices.

III. DEFINITIONS:

Accidental Injury: A non-intentional injury which was either witnessed by staff or self-reported and **requires** treatment by a nurse, physician, or outside medical care provider (more treatment than soap & water/simple band-aid).

Client-to-Client Physical Abuse (Assault): Action in which the intent is to cause bodily injury (physical pain, cuts, scratches, bruises, abrasions, or any impairment of physical condition caused by trauma) or any intentional physical action (this means that the contact was not by accident) to another which is of an intensity that a member of the general public would perceive it to be painful, regardless of whether the person expressed or demonstrated that it was painful.

Some examples of physical actions are:

a) Hitting, slapping, punching, kicking, and/or striking a person physically or with an object.
b) Pinching of skin.
c) Twisting of limbs or other body parts or pulling of hair.

Some examples which would NOT be considered abuse (assault) are:

a) Randomly throwing an object which hit another person by chance (vs. throwing the object at the person).
b) Accidentally knocking someone down.
c) Accidentally hitting someone while hitting or kicking randomly.

Elopement – Area (Elope-A): The individual leaves the sight and supervision of staff, but remains within the boundaries of the campus or the perimeter of the outing site. If the length of time that staff is unaware that the client has left the area exceeds 15 minutes, report the incident as neglect under R.L. #25 rather than as an SER under this policy.

Elopement – Off Campus (Elope-C): The individual leaves the boundaries of the campus or the perimeter of the outing site and is out of the sight and supervision of staff responsible for monitoring. If the length of time that staff is unaware that the client has left the area exceeds 15 minutes, report the incident as neglect under R.L. #25 rather than as an SER under this policy.

Injury Associated with Restraint: Any reported or visible injury that is visible fifteen minutes after the incident and occurs during any type of restraint including mechanical and chemical (for example, the client receives bruises during a prone restraint; abrasions from a mechanical restraint; falls and cuts their head due to being under the influence of a chemical restraint in the clinical judgment of the professional staff in attendance).

Injury of Unknown Origin: Any visible trauma, injury, or wound that was not witnessed and for which the client cannot communicate the cause. Note: Any injury of unknown origin which looks suspicious in nature such as bruising in a handprint pattern, bruising or scratches in the groin or breast areas, etc. should be reported as suspected abuse under ISSH policy R.L. #25 rather than included on Form #7055.

Left Unattended:

- An individual who does not have independent travel is left behind for five minutes or longer after the group has departed.
- An individual is left unsupervised for five minutes or longer in a restroom or other isolated area when supervision is needed.
- If the length of time that staff is unaware that the client is unsupervised exceeds 15 minutes, report the incident as neglect under R.L. #25 rather than as an SER under this policy.

Medical Emergency: Any incident requiring cardiopulmonary resuscitation (CPR), the Heimlich maneuver, transportation by 911 ambulance or an emergency evaluation/treatment in a hospital emergency room.

Pica Requiring Medical Intervention: Ingestion of cigarettes, cigarette butts, batteries, glass, metal or plastic items with sharp edges/points. Ingestion of a chemical or poison that requires treatment beyond monitoring after calling Poison Control Center.
Note: Ingestion of any other inedible substance is to be reported to Nursing so appropriate followup and monitoring can occur, but completion of a Significant Event Report is not required.

Self-Injurious Behavior (SIB):

- Any self-inflicted injury that results in blood or bruising.
- Any direct hit to the head or core body area (trunk and groin) in which the intensity would be perceived as painful by the general public.
- Repetitive (more than 5 times in 15 minutes) hits to the head or core body area (trunk or groin) which are of an intensity to cause red marks on the skin regardless of how long the marks remain.

Sexual Misconduct: Sexual behavior between unmarried people as defined below:

- Level 1: Touching over clothes in the breast, buttocks, or genital area with a sexual intent.
- Level 2: Skin contact to genitals, breast, buttocks; or self-exposure with a sexual intent.
- Level 3: Verbal threat(s) of a violent sexual nature or intentional/painful grabbing of genitals, buttocks, breasts.
- Level 4: Oral, anal, or genital intercourse; sexual penetration with a foreign object.

Suicide attempt: An act causing harm or attempting to cause harm to oneself with the expressed intent to kill oneself.

Suicide threat: A statement of the intent to kill oneself. (See RL #14 for further explanation of suicide issues.)

IV. PROCEDURE:

Significant Event Report & Investigation

Person Responsible	Event	Action
Any staff	Witness or receive report of event that meets definitions.	1. Take immediate action to protect the individual and others, as relevant. 2. Notify the charge person immediately. 3. For all events complete Sections A-E of Form #7055 *Significant Event Report* (SER) and give form to the nurse within **one hour of event.**

Table continued on next page

Charge Person	Receives notification of SER	1. Call the QMRP or designee immediately (Note: The AOD; RN/AOD is the designee between 5 p.m. and 8 a.m. and on weekends and holidays). 2. For Injury of Unknown Origin complete Section A #7055A and give to nurse within one hour of the event.
QMRP or designee	Receives notification of Level 4 sexual misconduct.	**Immediately do the following:** 1. Contact law enforcement and the Administrative Director. **Within one hour or as soon as you have taken steps to protect the victim or other potential victims:** 2. Prepare and fax the Report to Adult Protection if injured person is adult (18 years or older). 3. Fax copy of Form #7055 (SER) to Child Protection if injured person is a child (17 years or younger). 4. Document this contact in Section J of Form #7055 (SER).
QMRP or designee	Receives notification of serious injury **due to assault** (defined as Level 5 injury, i.e. needing treatment or admission to an outside facility).	**Immediately do the following**: 1. Contact the police department and the Administrative Director. **Within one hour do the following (or as soon as you have taken steps to protect the victim or other potential victims**): 2. Prepare and fax the Report to Adult Protection if injured person is adult (18 years or older). 3. Fax copy of Form #7055 (SER) to Child Protection if victim is a child (17 years or younger). 4. Document this contact in Section J of Form #7055 (SER). 5. If the event results in death, refer to policy Medical #10 - Death of a Client.
QMRP or designee	Receives report of client to client assault where the individual responsible for the event is 18 or older and victim is younger than 18.	1. Contact the Administrative Director. 2. Fax copy of Form #7055 to Child Protection. 3. Document this contact in Section J of Form #7055.
Nursing	Receives Form #7055 Significant Event Report	1. Conduct a physical examination and document any noted new injuries in OPFR charting. 2. Complete Section G of form #7055 (SER) and attach copy of OPFR charting.

Table continued on next page

Nursing		3. Notify guardian between the hours of 8 a.m. and 10 p.m. (refer to notification checklist in the chart to determine the type of event in which the guardian desires notification). 4. Document guardian notification on Form #7055 (SER) in Section H. 5. Give form and attachments to charge person before end of shift. 6. If unable to reach guardian, nursing staff will make at least one attempt on day shift and one on swing shift for three days following the event. 7. Document date(s) and time(s) of notification attempts in the Physician Progress notes. 8. After three days without success, notify the Social Worker and the QMRP.
Nursing	Injury associated with restraint	In addition to steps in the box above: 1. Take a photograph of the injury and place in OPFR section of the client services record.
Nursing	Finds new injury on physical exam or is notified of injury that is verified on physical exam AND event is *injury of unknown origin*	In addition to steps two boxes above: 1. Take a photograph of the injury and place in OPFR section of the client services record. 2. Initiate form #7055A Investigation of Unknown Origin and complete questions 1-5. 3. Attach OPFR charting if questions #2 and/or #5 are checked "yes". 4. Give forms #7055 (SER), #7055A Investigation of Unknown Origin and a copy of the related OPFR charting to the charge person.
Charge Person	Receives form #7055A from nurse	1. If cause is not determined, complete items 6, 7 & 8. 2. If cause is not determined, route copy of form #7055A to charge on each of the next two shifts, until all persons have been interviewed OR cause has been determined. 3. Ensure form is completed accurately, including all signatures, attachment of interviews, and route original to QMRP with #7055 **by the end of the shift.**
Charge Person on Other Two Shifts	Receives form #7055A from Charge Person initiating form	1. Complete question 8. 2. Ensure information is completed accurately, including all signatures, attachment of interviews and route to QMRP **within three calendar days.**
Charge Person	Receives form #7055 (SER)	1. Assure that the QMRP or designee was contacted & contact was documented.

Table continued on next page

Charge Person		2. Complete Section F. If enhanced supervision was not done properly or there are concerns about staff not providing adequate supervision for any client involved in the event, notify the QMRP or designee. Document the decision of the QMRP or designee in Section F. 3. Review form for accuracy and completeness including any applicable attachments (#7055A), ensure needed corrections and sign Section I. 4. Deliver original form(s) to QMRP and a copy of the front of first page to the Performance Improvement Department before the end of the shift (leave at Switchboard).
QMRP or designee	Notified of concerns regarding adequate supervision for any client involved in the event	1. Evaluate the event to determine whether Administration should be notified of concerns regarding supervision. 2. Instruct staff as to whether or not the event should be reported to Administration or designee. NOTE: Outside of normal business hours, the QMRP designee and AOD may be the same person.
Social Worker (or QMRP)	Receives notice of nurse's inability to contact guardian	1. Contact guardian (mail, telephone, or e-mail) within the next business day. 2. Forward documentation of contact to the QMRP.
QMRP	Receives form #7055, #7055A	1. Review form(s) within 24 hours of receipt and ensure completeness of all forms and attachments including documentation of guardian contact. 2. Complete questions appropriate for the type of event on form #7055B SER Team Review and Action Plan. 3. With input from appropriate treatment team members, develop, implement an action plan. Complete form #7055B SER Team Review and Action Plan within **5 working days** of incident. 3. Sign #7055B and route all forms, attachments and documents to Switchboard for Performance Improvement Department **immediately upon completion.**
Performance Improvement AA-1	Receives photocopy of initial report	1. Enter information into database.
Performance Improvement AA-1	Receives original copy of report	1. Enter team plan into database and file per FACS Records Retention Policy.
Performance Improvement Director	Monthly Review	1. Direct a review of a sample of completed reports to ensure thoroughness of plan and correct completion. 2. Assure any areas needing improvement are entered in the monitoring spreadsheet.

Table continued on next page

Performance Improvement Director	Quarterly Review	1. Present a report to the QMRP and Administrative Director which summarizes trends and recommendations for improvement.
Administrative Director	Receives Quarterly Report	1. Implements changes in facility practices as needed.

Monitor Events with the Potential for Injury or Resulting in Injury Not Meeting Criteria as Significant Events

Person Responsible	Event	Action
QMRP	Monthly Review	1. Review client records for the month to monitor for events with the potential for injury or resulting in injury that did not meet criteria for Significant Reporting as defined in this policy.
QMRP	Finds pattern of events with the potential for injury or resulting in injury that did not meet criteria for Significant Reporting as defined in this policy.	1. Investigate and, with appropriate team members, develop a plan of action based on the results of the investigation. 2. Summarize the investigation and document plan in the QMRP progress notes.

V. Attachments:

Form #7055 Significant Event Report
Form #7055A Investigation of Injury of Unknown Origin
Form #7055B Team Review and Action Plan

References: ICF/MR Regulations W122, W127, W148, W149, W150, W151, W152, W153, W154, W155, W156, W157, ISSH Policy Medical #10 – Death of a Client; R.L. #14, -- Suicide Precautions; Report to Adult Protection Form; Behavior Reporting Form

REVIEW: QMRPs, Performance Improvement
Required Reviews/Approvals: Policy Review Committee; Administrative Director
Review Date: 08/06 **Next Review Date:** 08/09
Originator/Date: S. Broetje, 12/05

Form #7055 (Rev 05/06)

SER #_____

SIGNIFICANT EVENT REPORT

Section A: Identifying Information (for all SER's)

Name: _____ 18 years or older? ❑ Yes ❑ No CSU: _____

Location of event: _____ Date of event: _____ Time of event: _____

Name of reporting staff (please print and sign) _____ Title: _____

Name of perpetrator if any: _____ Date of report: _____

Section B: Initial Reporting - Reporting staff is to call immediately (for all SER's)

For all SER's ❑ Contact QMRP or ❑ Contact AOD	Date:	Time: am/pm	Signature of staff making contact:
❑ Contacted Administrative Director For Unknown Injury, Client-to-Client Assault, SIB, SM level 4, Suicide Attempt.	Date:	Time: am/pm	Signature of staff making contact:

Section C: Type of Event and Minimum Documentation Needed (for all SER's)

√	Event	Attach
	Accidental Injury*	OPFR Charting
	Injury Assoc. w/Restraint*	OPFR Charting
	Injury of Unknown Origin	OPFR Charting 7055A
	Medical Emergency	OPFR Charting
	Other (Specify):	Attach narrative describing event

Answer the appropriate question below

√	Event	Attach
	Left Unattended*	OPFR Charting
	Elope-A*	OPFR Charting
	Elope-C*	OPFR Charting
	PICA w/ medical Intervention	OPFR Charting
	Client to Client Assault	Behavior Report Form OPFR charting if injury
	SIB	Behavior Report Form OPFR charting if injury

*Answer the appropriate question below

√	Event	Attach
	SM/Level 1**	Behavior Reporting Form
	SM/Level 2**	Behavior Reporting Form
	SM/Level 3**	Behavior Reporting Form OPFR Charting
	SM/Level 4**	Behavior Reporting Form Physician Progress Notes OPFR Charting
	Suicide Threat	Behavior Report Form Suicide Assessment
	Suicide Attempt	Behavior Reporting Form Suicide Assessment OPFR Charting

**Complete form for each person.

Section D: Accidental Injury, Injury during restraint, Elopement or Left Unattended only. Fill out this section. If not, line out this section. If needed, attach another page.

1. For **Accidental Injury**, describe what action/activity contributed to the event (environmental issues, the individual's behavior, etc.) & briefly describe the event including any actions taken to prevent further occurrences where relevant.

2. For **Injury During Restraint**, describe **how** the injury occurred and at **what point** during the restraint process. Be specific (ex. scratched himself on the arm while struggling during the standing part of the restraint).

3. If this was **Elopement** or **Left Unattended,** answer the questions below:
   a. Who first noticed the individual was missing?_____
   b. Where was the individual last seen?_____ At what time? _____am/pm
   c. Who found the individual? _____At what time? _____am/pm
   d. Where was the individual found?_____
   e. Briefly include a description of what actions/activities led to the individual not being supervised:

Provide answer to question 1, 2 or 3 here if needed:

_____

_____

_____

_____

_____

_____

_____

Section E: *What was staff doing at the time of the event?* (If more than four, attach another page).

Form #7055 (Rev 05/06) SER #_____

SIGNIFICANT EVENT REPORT

If Injury of Unknown Origin skip this section and fill out 7055A

Staff's Name: _____Name of client:_____ ___Positively engaged with client. ___Implementing BMP ___Directing client group. ___Visually monitoring clients ___Recording data etc. ___Side duties without clients. ___Other (describe)	Staff's Name: _____Name of client:_____ ___Positively engaged with client. ___Implementing BMP ___Directing client group. ___Visually monitoring clients ___Recording data etc. ___Side duties without clients. ___Other (describe)
Staff's Name: _____Name of client:_____ ___Positively engaged with client. ___Implementing BMP ___Directing client group. ___Visually monitoring clients ___Recording data etc. ___Side duties without clients. ___Other (describe)	Staff's Name: _____Name of client:_____ ___Positively engaged with client. ___Implementing BMP ___Directing client group. ___Visually monitoring clients ___Recording data etc. ___Side duties without clients. ___Other (describe)

Description of Event (filled out by reporting staff)

1. What was the scheduled activity in and around the time of the event?_____

2. What other factors may have influenced the individuals' (or victim's) behavior?_____

3. Did the person responsible for the event display any unusual behaviors before the event? ❑ Yes ❑ No
   - If yes, describe: _____
   - If yes, what was done to address the behavior before the event? _____

4. What immediate action was taken to protect the person responsible for the event and others from harm?

5. What was the victim's reaction to the event? (Check all that apply.)

❑ No reaction	❑ Diminished Responsiveness	❑ Hyper-Vigilance	❑ Retaliated or Attempted to
❑ Anger	❑ Social Withdrawal	❑ Vocalized Distress	❑ Verbalized Distress
❑ Fear	❑ Exaggerated Startle Response	❑ Expressed Distress by Facial or Physical Actions	
❑ Agitation	❑ Engaged in Self-Injurious Behavior	❑ Other (specify) _____	

6. Was the victim injured? ❑Yes ❑No If no, is there potential for later bruising, etc.? ❑Yes ❑No

Section F: Client Supervision (To be filled out by charge staff only)

1. Was Enhanced Supervision in place for any client involved in this event ❑Yes ❑No
2. What level ? ❑Arm's length ❑Close Proximity ❑ Heightened ❑ NA
3. Enhanced supervision done properly? ❑Yes ❑No ❑NA if no contact QMRP (or designee) immediately.
4. Do you have concerns about staff not providing adequate supervision for any client involved in this event? ❑Yes ❑No if yes contact QMRP (or designee) immediately, to evaluate.

QMRP (or designee) Decision: ❑ Continue SER ❑Continue SER & Notify Administrator/AOD

Section G: Physical Examination (For all events. Completed by Nursing)

Form #7055 (Rev 05/06)

SER #_____

SIGNIFICANT EVENT REPORT

√	Level of Injury		
	Level 0: No apparent injury		Level 4: Physician treatment required
	Level 1: No treatment or DDT could provide (even if nurse actually provided)		Level 5: Treatment at outside facility Name of facility:
	Level 2: Nursing treatment required		Level 6: Admitted to outside facility Name of facility:
	Level 3: Physical evaluation required, no further treatment		

Nurse Signature: _____ Date: _____

Be sure to include all attachments as reflected on page 1.

Section H: Guardian Contact (For all events. Completed by Nursing/SW/QMRP)

❑ Guardian does not want to be contacted for this type of event. ❑ Client does not have guardian ❑ Guardian contacted on _____(date) Name of person making contact:
Unsuccessful attempts to contact guardian are to be documented in the physician's progress notes.

Section I: Form Review and Delivery (Completed by the charge person)

❑ Review forms for accuracy and completeness ❑ Deliver original to QMRP & copy to Switchboard for Performance Improvement by end of shift	Signature:

Section J: Reporting to Outside Agencies (Completed by the QMRP or AOD)

Complete and fax Report to Adult Protection if event is: (forms are at Switchboard): ❑ Level 4 sexual misconduct ❑ Death ❑ Serious injury **due to assault** (defined as Level 5 injury)	Date faxed: Signature:
Complete and fax this SER to Child Protection if event is: ❑ Level 4 sexual misconduct ❑ Death ❑ Serious injury **due to assault** (defined as Level 5 injury) ❑ Client to client assault where victim is under 18	Date faxed: Signature
Report to Law Enforcement if event is: ❑ Level 4 sexual misconduct ❑ Serious injury **due to assault** (defined as Level 5 injury)	Date contacted: Signature:
The Administrative Director/AOD must also be contacted when contacting adult/child protection or law enforcement.	Date contacted: Signature:

Form #7055A (5/6) SER#_____

INVESTIGATION OF INJURY OF UNKNOWN ORIGIN

Fill out this page only for unknown injuries

ote: If during the course of the investigation, you are able to determine the cause of the injury; all sections do not need to be completed.
orm to be completed within five working days of event. Please forward to the Performance Improvement Department.

Name: _____ CSU: _____

Location of event: _____ Date of report: _____ Time: _____

Name of reporting staff (please print): _____ Title: _____

Nursing

1. Does the injury appear to be new (i.e., within the current day)? ❑ Yes ❑ No

2. Review medical documentation (i.e., OPFR charting). Were there any documented incidents that might have resulted in the type of injury reported? ❑ Yes ❑ No If yes, attach copy of the charting.

3. Interview the client. Ask questions as to by whom, what, where, and when the injury might have happened. Did the client have any idea what might have happened? ❑ Yes ❑ No ❑N/A (unable to self-report). If yes, describe what the client thinks might have happened:

_____

_____

4. Is the client on any medication or have a condition that might have contributed to the effect or cause of the injury, e.g., blood thinning medications, episodes of unsteady gait, lethargy, etc.? If any were noted, list:

_____

5. Has the client received the same or similar injuries in the past 3 months? ❑ Yes ❑ No If yes, attach copy of relevant OPFR charting.

harge staff

6. Inspect areas where the individual had been (within 24 hours for new injury and within 72 hours for older injury) and look for contributing factors. Were any factors found or suspected to be contributing to the injury?
❑ Yes ❑ No ❑N/A If yes, describe what action was taken to prevent future occurrences:

_____

_____

7. Review documentation (i.e., behavior and restraint data, group communication logs, previous SERs). If the injury appears new, you need only review documentation for the past 24 hours. If not, review documentation for the past 72 hours. Were there any documented incidents that might have resulted in the type of injury reported? ❑ Yes ❑ No
If yes, describe:

_____

_____

8. Interview all staff who had contact with the client during the time frame determined in question #6. Ask open-ended questions as to who, what, where, and when any incidents occurred involving the client. Use only facts. On separate pages document and attach each interview, including the **name of the person interviewed, date of interview, shift the person worked, and statements**. (Note: Charge staff from each shift may need to complete this section if cause is not immediately determined.)

QMRP

9. Conclusion of investigation: Attach information on how you made the following conclusions
❑ Unable to determine cause of injury or make a viable hypothesis
❑ Unable to determine cause of injury, but the following is the most likely cause
❑ Cause of injury was determined during the course of the investigation

Signatures of individuals completing the investigation:	*Date*	*Signatures of individuals completing the investigation*	*Date*
Nursing:		NOC DDS/charge:	
AM DDS/charge:		Other:	
PM DDS/charge:		QMRP Review:	

Attach OPFR charting (where relevant) and copies of interviews

Form #7055B (Rev 5/6)

SER #_____

Team Review and Action Plan

Complete within five working days of event, attach to the SER and forward to Performance Improvement Department.

Name: _____ 18 years or older? ❑ Yes ❑ No CSU: _____

Location of event: _____ Date of event: _____ Time: _____

Name of reporting staff (please print): _____ Title: _____ Date of report: _____

QMRP – Make sure to add items listed below to your team review and action plan write-up.
When done place check in ○

○ For **restraint injury,** interview any witnesses and staff involved and answer the following:
- Why did staff feel that they could not use less restrictive interventions, i.e. redirection, escort from area, move away, etc.?
- Did all staff feel they were sufficiently trained to perform the restraint?
- Did all staff present state that the restraint was properly applied?

○ For **sexual misconduct,** interview individuals and staff and answer the following:
- Why did this individual engage in sexual contact?
- In the plan below, list corrective action taken or planned to prevent recurrence and assist the individual in coping with the psychological distress.
- Were staff following instructions in individual program plans?
- If not, include an explanation and corrective action taken or planned in plan below.

○ For **suicide threat or attempt,** answer the following:
- Did the individual demonstrate signs of depression?
- Were there any circumstances that occurred prior to the threat or attempt?
- What actions were taken to assist the client in dealing with this issue?

○ For **client to client assault,**
- List the number of times the adult responsible has assaulted another client in the past 30 days.
- If the adult responsible for the event has assaulted four or more other clients in the last 30 days, write up report, then fax to Adult Protection and attach a copy.

○ For **Client Supervision** issues: If the QMRP made a decision on this section, please explain

Attach Team Review and Action Plan

Check team actions taken or planned:
❑ Staff training ❑ Staff disciplinary action ❑ Environmental changes ❑ Program strategy changes ❑ Other

QMRP Signature_____ Date _____

DEPARTMENT OF HEALTH AND WELFARE
IDAHO STATE SCHOOL & HOSPITAL
NAMPA, IDAHO

Operating Policy and Procedures

Subject: Medical Restraint		**ISSH Policy:** Med. #34 Page 1 of 7
Effective date: July 26, 2006	**Supersedes:** R.L. #1 Dated 07/14/00	**Approved by:** SBuetje **Date:** 7/31/06

I. PURPOSE:

To ensure that individuals with developmental disability receive medical care and treatment that meets community standards of care, it is necessary to establish procedures for the application and monitoring of medical restraint while ensuring the welfare and human rights of individuals are adequately protected.

II. POLICY:

Medical restraint is defined as a restraint ordered by a physician or dentist to facilitate the safe conduct of a medical treatment, or to protect an individual from injury during or following a medical or dental procedure.

- Medical restraint may be in physical, mechanical or chemical form (sedation).
- The client must be responding to a specific medical intervention or treatment and the behavior and restraint would not have occurred in the absence of the medical intervention or treatment.
- Medical restraint may be used in an emergency when its use was not planned for or anticipated, and the restraint is needed for the safe completion of the medical procedure or treatment.
- When repeated planned or emergency use of medical restraint(s) occurs, programs for medical restraint to decrease resistance to medical procedures (as appropriate) will be incorporated programmatically into the individual's Person Centered Plan (PCP).

III. PROCEDURE:

A. A physician's order is obtained for all medical restraint.
   1. The physician's order will include the restraint to be applied, the medical intervention or treatment being provided, and conditions for release from restraint.
   2. A physician's order for medical restraint can be obtained for a future specific one-time medical need. Example: May use physical restraint to obtain blood draw.

3. Once initiated, orders for medical restraint (physical or mechanical) shall be in effect no longer than 12 hours. This applies to one-time and on-going need for medical restraint.
   a. Reorders extending beyond the original 12 hours shall be requested from the physician only after review of the client's condition.
   b. If renewal of medical restraint order is needed, a nurse will assess the client and document his/her observations (i.e. medical need; client response to medical restraint; effectiveness of medical restraint in protecting the client's health and safety) of the client's status/condition on Form #6510 – Medical Restraint Documentation Form (Nursing Attachment B) every 12 hours.

B. Consent for medical restraint:
   1. Consent will be obtained from the appropriate party prior to the use of any medical restraint that is planned for or can be reasonably anticipated.
   2. When an emergency medical restraint is used, the guardian will be notified. Consent will be obtained if the reason for the emergency medical restraint continues and the restraint order is renewed. See Procedures A.3.

C. Documentation:
   1. All medical restraint must be recorded, regardless of duration.
   2. Use of medical restraint is documented on either Form #7020 – Medical Restraint (Nursing Attachment A) or the Restraint Sheet on the Behavior Reporting Form (BRF).
      a. Restraint is documented by the individual who is applying the restraint. Examples: Physical restraint applied by direct care staff is documented on the Restraint Sheet; restraint applied in the clinic areas is documented by the Clinic Nurse on Attachment A in the client services record.
      b. Identify and mark whether the restraint is an emergency or programmatic; behavioral or medical. Note: Only medical restraint is documented on Attachment A in the client services record.
      c. Mark the box indicating the type of restraint; Physical, Mechanical, or Chemical (Sedation).
   3. Attachment B is completed by Nursing for all medical restraint. Attachment B identifies the specific reason for the restraint and the steps taken prior to using the restraint.
   4. When completed by Nursing, Attachments A and B are found in the Nursing section of the client services record.
   5. At least 30-minute checks are required for physical and mechanical restraint and are documented by the individual who is monitoring the restraint on either the Restraint Sheet or Attachment A.

6. All releases from restraint every 2 hours for exercise, liquids and access to the bathroom are recorded.
   a. When restraint must be reinitiated because the client is putting himself at risk, a new entry is made with a new start time.
   b. When the client is not released for the full 10 minutes due to the need to protect the client or others, the reason should be documented in the comments section of the Behavior Reporting Form.
7. All Nursing Attachment A forms for the previous month are copied and provided to the Clinician by the 10th of the following month.

D. Medical Physical Restraint:
1. Physical restraint is applied as directed by medical personnel to allow access to the part of the body being treated or examined.
2. At no time should a visual check of the individual being restrained exceed 30 minutes; 30-minute checks are documented on the Restraint Sheet or Attachment A. This check should include ensuring proper body position for physical restraint. Adjustment must be made as needed to decrease potential for discomfort or injury.
3. Physical restraints that restrict the motion of a limb or joint require that every 2 hours an attempt be made to release the client for not less than 10 minutes and given the opportunity for exercise, access to the bathroom and liquids. See Procedures Section C.6.

E. Medical Mechanical Restraint:
1. The mechanical restraint used for most medical procedures is the Adult Restraint Board (ARB). Mechanical restraints which may also be used as medical restraints include wrist restraints, wheelchair seatbelts, mitts, and helmets.
2. A client may be placed in the restraint each time the behavior requiring restraint occurs as long as it is specified in the conditions of the original order and within the time frames of the original order. See Procedures Section A.
3. For mechanical restraint of multiple parts of the body, the application and release of each restraint is recorded as a separate entry if applied or released at different time intervals.
4. At no time should a visual check of the individual being restrained exceed 30 minutes; 30-minute checks are documented on the Restraint Sheet or Attachment A. This check should include ensuring proper fit of mechanical devices. Adjustment must be made as needed to decrease potential for discomfort or injury.
5. Mechanical restraints that restrict the motion of a limb or joint require that every 2 hours an attempt be made to release the client for not less than 10 minutes and given the opportunity for exercise, access to the bathroom and liquids. See Procedures Section C.6.

6. If mechanical restraint usage is expected to extend beyond 14 days (e.g. to protect surgical site or to prevent re-injury), the following process will apply:
   a. A written service program will be developed which will minimally specify why the restraint is needed (intrusiveness of restraint is weighed against benefits), criteria for restraint removal, less restrictive attempts that have proven ineffective, and who will monitor.
   b. Guardian consent, and Human Rights Committee (HRC) approval of the program is required. Once the program approvals are received, nursing will stop completing Attachment B and renewing physician's orders for restraint every 12 hours.
   c. The Treatment Team will review this program every 30 days.
   d. An order to discontinue the medical restraint will be requested of the physician when the reason for the restraint is resolved.

F. Medical Sedation (chemical restraint):
   1. The physician may need to prescribe sedation as part of normal medical management. The decision to use sedation for medical appointments is made by the physician on an individual basis with input from the Interdisciplinary Team. Medical sedation orders are to be utilized only when absolutely necessary for client protection.
   2. Nursing will verify a valid informed consent prior to administering medication for sedation.
   3. Following administration of medication for sedation, all staff should observe and report to nursing immediately any of the following: breathing difficulty; blue fingertips; loss of color in nail beds; cold extremities; any change in the level of consciousness.
   4. On the rare occasion, when more than one dose of medication is given/required for the purposes of sedation (e.g. client must remain calm during immediate postop period), the physician and/or nurse will document in the program record the potential adverse outcomes if sedation is not administered. Guardian consent will be obtained for sedation if need for continued sedation exceeds 48 hours.

G. Less restrictive measures will be considered and documented in the client services record prior to the initiation of medical restraint. A hierarchy of interventions is to be followed from least to most restrictive.** Deviation in the sequence is only permitted in situations where there is risk to the client's health and safety if the treatment or procedure is not performed.
   1. Verbal request to comply
   2. Physical assistance (one person, i.e. hand over hand)
   3. Re-evaluate client's need for scheduled appointment
   4. Rescheduling the appointment

5. Physical restraint
6. Mechanical restraint
7. Physical or mechanical restraint with sedation/conscious sedation
8. Sedation may come before physical or mechanical sedation in certain situations

** Nitrous Oxide in dental procedures may be used before other types of medical restraint per recommendation of the dentist. See Nitrous Oxide Policy, Medical #7.

H. Emergency Use of Medical Restraint:
1. Medical restraint may be used when it is necessary to initiate restraint in order to safely complete or discontinue a medical procedure or treatment. When emergency medical restraint is applied in an emergency, a physician's order is obtained as soon as possible and the guardian is notified per their request on the Guardian/Parent Notification Information Form #4102.

I. Safety Precautions:
1. Physical restraint will be applied so as to avoid holding over joints or applying pressure across the chest.
2. Mechanical restraint devices will be applied and checked so the breathing and circulation are not compromised.
3. Individuals who are restrained using the Adult Restraint Board will be continually visually monitored for signs and symptoms of respiratory distress.

J. Routine or Periodic Medical Restraint -- If medical restraint is required periodically or routinely for maintenance medical and dental procedures, the following process will be followed:
1. Individual responses to medical procedures will become part of the annual PCP (Summary of Individual Characteristics, Medical Status).
2. Medical restraint usage will be reviewed by the Treatment Team to discuss the need for a program(s) to provide medical treatment and/or training to decrease resistance to the medical procedure.
3. A program(s) will be written unless the Interdisciplinary Treatment Team can clearly document previous programmatic attempts, potential harm to the client, or contrary data.

IV. DEFINITIONS:

A. Restraint Data Sheet: Used to document medical restraint when it is applied by direct care staff at the direction of Nursing; the Restraint Data Sheet is found on the Behavior Reporting Form (BRF).

B. **Attachment A – Nursing:** Used to document medical restraint applied or sedation administered by Nursing. Attachment A is filed in the Nursing section of the client services record.

C. **Behavioral Restraint:** Used only to prevent an individual from harming her/him self or others. It includes physical, mechanical, and emergency chemical restraint. See Policy R.L. #1 – Behavioral Restraint.

D. **Sedation:** The administration of *emergency* or *programmatic* one-time doses of psychotropic medication to facilitate the safe provision of medical care and treatment when the person's behavior is uncontrollable by other less intrusive methods. Sedation is referred to as a chemical restraint for the purposes of this policy.

E. **Medical Restraint – types of restraint:**

1. **Emergency Medical Restraint:** The unplanned or unanticipated use of restraint and there is no current program to authorize restraint. Emergency restraint includes physical restraint, mechanical restraint, and chemical restraint.
2. **Planned Medical Restraint:** Medical restraint is considered planned when there is a medical need, a high likelihood of need for restraint, time to complete the informed consent process, and no written program in place. Example: A physician's order to physically restrain if needed to remove sutures in five days.
3. **Programmatic Medical Restraint:** The planned use of restraint as described and authorized in an approved written program in the individual's PCP. Physical, mechanical, and chemical restraint can all be used programmatically.

F. **Mechanical Restraint:** The use of a device that cannot be easily removed and that restricts the free movement of, normal function of, or normal access to a part of a person's body. Medical mechanical restraints may include Adult Restraint Board (ARB), wrist restraints, wheelchair seatbelts, mitts, and helmets.

G. **Physical Restraint:** This includes any body to body contact that restricts the free movement of or limits the range of motion of an individual or an individual's body parts.

H. **Restraint:** Defined as any manual (physical) method, or mechanical device that restricts the free movement of, normal functions or, or normal access to a portion or portions of a person's body. In general, techniques that limit a client's movement when the client resists, are considered restraint.

Exclusions from the definition of "Restraint" are:

1. Physical guidance and prompting techniques of brief duration. Prompting is a teaching technique and is not designed to overpower a client should she/he resist.
2. Mechanical devices to support proper body positioning or alignment.
3. Physical support for a treatment or procedure; for example, blood draws – provided there is no resistance by the client.

V. ATTACHMENTS:

Attachment A: Form #7020 - Medical Restraint
Attachment B: Form #6510 - Medical Restraint Documentation Form

References: ICF/MR Regulations; R.L. #1 – Behavioral Restraint; Medical #12 – Written Informed Consent; Medical # 7 – Nitrous Oxide

REVIEW: Clinical Director; Nursing; Policy Review Committee
Required Reviews/Approvals: Policy Review Committee; Administrative Director
Review Date: **Next Review Date**: 07/09
Originator/Date: L. Hayes, RN, DNS 7/06

ISSH #7020 R.L. #34
Revised 7/06

Attachment A - Medical Restraint

Completed when nursing applies medical restraint or administers sedation.

Name: MONTH/YEAR:

File: Living Area/Unit:

Date	Time In	Time Out	Prog	Plan	Emer	Phys	Mech	Sed-ation	30 Min Check		Staff Signature	Comments - identify the medical procedure or treatment

At the end of each month, this form is copied and forwarded to the clinician by the 10th of the following month.

NOTE: Mark all appropriate boxes for each restraint use.

PROGRAM (Prog) –Restraint is being used as per instructions in the PCP.

PLANNED (Plan) – Restraint was anticipated; there is consent for restraint and no program/plan exists.

EMERGENCY (Emer) - Unplanned or unanticipated use of restraint and there is no current program to authorize restraint.

PHYSICAL (phys) – Physical restraint applied as directed by medical personnel to allow access to the part of the body being treated or examined.

MECHANICAL (Mech) – Identify the restraint used (i.e. ARB, wrist restraints, helmet, etc.)

MEDICAL RESTRAINT DOCUMENTATION FORM

To Be Used For All Medical Restraint

Client's Name:	**Living Unit/Group:**	**File No.:**

Date:_____Time:_____Treatment Team Review Date: _____ ☐ N/A

Medical condition being treated:_____

Specific behavior/reason for restraint:_____

_____

Type of restraint: ☐ Physical ☐ Mechanical ☐ Sedation

If a sedation order, date to be administered (if known):_____ Date not yet determined. ☐

What steps were taken prior to using restraint? (Be specific)

1._____

2._____

3._____

Physician ordering the restraint:_____

_____ _____.

Signature of nurse completing form date

Restraint usage to be recorded on Restraint Sheet or Attachment A.

If the medical restraint needs to be continued the following section will be completed each 12 hours. Reorders extending beyond the original 12 hours shall be issued by the physician only after assessment and documentation by nursing of the client's condition (medical need; client response to medical restraint; effectiveness of medical restraint in protecting the client's health and safety).
Refer to RL #34, Section A.3.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client's Name:	Living Area/Group:	File No.:

DEPARTMENT OF HEALTH AND WELFARE
IDAHO STATE SCHOOL AND HOSPITAL
NAMPA, IDAHO

Operating Policy and Procedures

Subject: Enhanced Supervision		**ISSH Policy:** R.L. #35 Page 1 of 3
Effective date: June 5, 2006	**Supersedes:** R.L. #35 dated 4/1/06	**Approved by:** SBroetje **Date:** 6/5/06

I. PURPOSE:

Periodically, clients require enhanced supervision to ensure safety. This policy provides guidelines for the use of enhanced supervision so that: a) it will only be used when necessary, b) that it is implemented in such a way as to ensure client safety, c) that proper review occurs, and d) measures are taken to determine how and when enhanced supervision is discontinued.

II. POLICY:

Enhanced supervision is defined by a series of different supervision levels. The hierarchy of supervision levels can also be used for fading purposes. The levels of supervision are:

1. Arm's Length Supervision: An assigned staff person maintains supervision at a distance no greater than three (3) feet and is able to intervene immediately as needed.
2. Close Proximity Supervision: An assigned staff person maintains supervision at a distance of no greater than approximately twenty (20) feet and is able to intervene within ten (10) seconds.
3. Heightened Supervision: The staff in the area must know where the person is at all times and visually observe the person at intervals no greater than fifteen (15) minutes.
4. General Supervision: The staff in the area must know where the person is at all times and visually observe the person every fifteen (15) minutes, unless the individual is engaged in independent activities in their bedrooms.

The first two levels, **Arm's Length** and **Close Proximity,** require approval from the Clinical Director or designee prior to their implementation and a dedicated staff person is assigned. Any staff person assigned to Arm's Length or Close Proximity supervision of an individual must have received training on the enhanced supervision plan; a trained core staff member is preferred.

NOTE: Suicide precautions are addressed in R.L. #14 and do not require enhanced supervision approvals stated in this policy unless implementation of suicide precautions exceed 72 hours. After 72 hours, an Enhanced Supervision Plan (Attachment B) is completed and submitted to the Clinical Director.

III. PROCEDURE:

Enhanced Supervision – Short Term (less than 30 days)

A. When a supervisor/charge person decides that enhanced supervision (Arm's Length or Close Proximity) is required, following a particular incident or event, that supervisor will complete an *Initial Request for Enhanced Supervision* form *(Attachment A)* and submit it to the AOD, Clinical Director, designee or Administrative Director for approval. Administrative approval must be obtained before the enhanced supervision can begin.

NOTE: The *Initial Request for Enhanced Supervision* form is completed for both medical and behavioral requests.

1. During non-business hours (weekends, evenings and holidays), the AOD reviews the *Initial Request for Enhanced Supervision* and can authorize up to 72 hours of enhanced supervision or until the next business day, which ever is shorter.
2. Upon completion and approval of enhanced supervision, the AOD will place the original in the Interdisciplinary Team Section of the client services record with copies to the QMRP and Clinical Director.

B. On the next regular business day the Treatment Team will meet to determine whether continuation of enhanced supervision is deemed necessary. Once the Team makes this determination, they will submit an *Enhanced Supervision Plan (Attachment B)* to the Clinical Director by the morning of the next (second) business day. The Clinical Director authorizes and signs the plan for enhanced supervision and a date is set for the next review.

1. The Clinical Director authorizes and signs the plan for enhanced supervision and a date is set for the next review.
2. The QMRP places original Enhanced Supervision Plan (Attachment B) in the Interdisciplinary Team Section of the client services record.

C. Identification of levels of enhanced supervision for staff.

Each client's level of supervision will be identified in their individual schedule and in the Communication Log. This pertains to the first three levels of enhanced supervision: arms length; close proximity; and heightened supervision.

Enhanced Supervision – Long Term (greater than 30 days)

A. If enhanced supervision is expected to be long term, i.e., longer than 30 days, the Team completes and re-submits the *Enhanced Supervision Plan (Attachment B)* with the addition of a plan to fade the enhanced supervision (See Section #6).

1. Attachment B and the fading plan are submitted to the Behavior Review Committee (BRC) and to the Clinical Director for approval.

2. The strategies specified in the long term plan are incorporated into the PCP within 45 days from the initiation of the enhanced supervision.

3. The QMRP places original Enhanced Supervision Plan (Attachment B) in the Interdisciplinary Team Section of the client services record.

B. Review of the Enhanced Supervision Support Plan occurs at several levels.

1. The DDS checks the data daily.

2. The QMRP checks the data at least weekly.

3. The Clinical Director reviews the Support Plan monthly, or at designated one (1) to three (3) month intervals, depending upon circumstances.
   a. The *Enhanced Supervision Plan Monthly Review* form *(Attachment C)* is filled out by the Team for review by the Clinical Director.

4. When Enhanced Supervision lasts 3 months it requires review by:
   a. The Behavior Review Committee
   b. Clinical Director
   c. Administrative Director

   Thereafter, the Plan is reviewed by BRC at 3 month intervals (prior to review by the Clinical Director).

C. Identification of levels of enhanced supervision for staff.

Each client's level of supervision will be identified in their individual schedule and in the Communication Log. This pertains to the first three levels of enhanced supervision: arms length; close proximity; and heightened supervision.

R.L. #35 Attachment A

Initial Request for Enhanced Supervision

(To be completed by Supervisor or AOD)

Client Name: _____ CSU: _____

Date of Request: _____ Requested By: _____

1. Specify the level of supervision requested:
   ❑ Arm's Length ❑ Close Proximity

2. Describe the specific **Purpose** of Enhanced Supervision (including whether medical or behavioral):

   _____
   _____
   _____

3. Describe alternatives considered and why these were considered inappropriate or ineffective. What interventions had been tried previously? How effective were they?

   _____
   _____
   _____

4. What shifts / partial shifts / hours of the day is the request for?

   _____
   _____

5. Outline specific duties and staff actions during enhanced supervision for each shift that will be in effect until review by the Treatment Team. Describe how staff will address medical needs, comfort measures, behavioral issues/supports, programmatic needs and restrictions.

   Day Shift

   _____
   _____
   _____

   Swing Shift

   _____
   _____

   Night Shift

   _____
   _____

Clinical Director/Designee/AOD Initial Authorization:

_____ _____

Signature Date

Initial Request for Enhanced Supervision

(To be completed by Treatment Team on next business day after initiation of ES)

Client Name: _____ CSU: _____

Level of Enhanced Supervision (ES) currently in place:

❑ Arm's Length ❑ Close Proximity

Date Initiated: _____

Treatment Team Meeting (Date & Time): _____

TEAM DECISION:

❑ Enhanced Supervision discontinued _____
(Date)

❑ Enhanced Supervision – **Short Term** (less than 30 days) to continue.

1. Treatment Team will submit *Enhanced Supervision Plan*, Attachment B, to Clinical Director on next business day)
2. Clinical Director may authorize and sign *Enhanced Supervision Plan* and set a date for the next review.

_____ _____
QMRP Signature Date

_____ _____
Clinical Director Authorization Date

Next Review Date: _____

TEAM DECISION:

❑ Enhanced Supervision discontinued _____
(Date)

❑ Enhanced Supervision – **Long Term** (greater than 30 days) to continue.

1. Treatment Team re-submits *Enhanced Supervision Plan,* Attachment B, with the addition of a plan to fade the ES to Behavioral Review Committee (BRC) and Clinical Director for approval.

_____ _____
QMRP Signature Date

R.L. #35 Attachment B

Enhanced Supervision Plan

(To be completed by Treatment Team)

Client Name: _____ Date: _____

QMRP: _____ CSU: _____

Level of Enhanced Supervision (ES) currently in place:
❑ Arm's Length ❑ Close Proximity

Date Initiated: _____

Instructions to Staff:
On a separate document use a modified BSP/Training Program format and address each item listed below:

1. Specify Levels of ES for each shift.

2. Locations covered:
   a) All locations _____
   b) Only in certain locations ____ (specify)
   c) Specify exceptions _____ (e.g., bathrooms, home visits, bedroom, etc)

3. What is the desired outcome for the use of ES?

   A. List **target behaviors** that are indicators for the need for ES and type of data (e.g., assaults, ounces of liquids consumed, falls, etc). These may be recorded on the BRF or special data sheet designed for the ES staff.

4. What data will indicate the success of ES?

   A. Clearly define the data collection expectations for all staff collecting data.
   B. Use of a **Narrative 15-minute interval recording** form is mandatory. Define data to be recorded that is specific to the client and his/her problem (e.g., activities offered, level of prompting, participation, refusals, reinforcement, sleeping, mood, etc.).
   C. An **individualized active treatment schedule** should accompany the narrative 15-minute interval record. If the active treatment schedule is not current, provide a current schedule.
   D. Use **ABC narrative records**, unless not pertinent. Use a separate sheet to record antecedents and consequences for behaviors that are indicators for the need for ES. ABC records may be specified for additional behaviors, including adaptive behaviors.
   E. Identification of **adaptive/replacement behaviors**, either new or previously identified, and corresponding procedures for prompting and reinforcement.

Enhanced Supervision Plan

(To be completed by Treatment Team)

F. **Instructions to staff** on how to respond to any identified environmental or behavioral antecedents for challenging behavior or any indicators of the need for ES.
G. **Instructions to staff** on how to respond to the identified target behaviors.

5. **Review and monitoring**:
   A. The DDS/charge person will review the data each shift - this includes the BRF; the 15-minute interval narrative; and the ABC data.
   B. If problems are identified in implementation of procedures or data, the QMRP should direct the DDS to complete several Direct Observation Evaluations (DOEs).
   C. The ID team should review the data and status of the client weekly, at least for the first 30 days, and document this in the team minutes.
   D. The QMRP completes a monthly progress note reviewing the data for progress, changes in levels of supervision, medication changes, changes in programmatic methods, target behaviors, etc.
   E. The team completes the ES monthly review form for review by the Clinical Director.

If after 30 days the team intends to continue ES, the team must provide a fading plan. The fading plan should include the information listed below:

6. **Fading Plan:**
   A. Discuss current status of ES.
   B. Outline steps of a fading procedure. The hierarchy of ES from arm's length to general supervision is one possible dimension for fading and it is recommended that this be considered first.
   C. Other possible dimensions to consider are time of day, different locations and different activities. These may be combined with letter 'B' above.
   D. The fading plan should also contain criteria for moving from one step to the next. In addition, criteria for backing up to the previous step should be included in the plan for fading ES.
   E. If the team does not believe fading should be attempted at this time, a plan for fading should still be developed. A rationale based on data and a risk analysis should explain why fading will not be attempted at this time. In addition, criteria should be identified for when fading will begin.

R.L. #35 Attachment C

Enhanced Supervision Plan
Monthly Review

(To be completed monthly by Treatment Team)

Client Name: _____ Date: _____

QMRP: _____ CSU: _____

Date of Treatment Team Meeting: _____

Team members present:

_____
_____
_____
_____

1. Has there been a change in the level of supervision? If so, please describe in detail. How has the individual responded to the ES? Is the ES aversive to the person? Does he/she like the ES? Does the person prefer certain staff members?

_____
_____
_____
_____
_____
_____
_____

2. Present data on target behaviors. Include baseline data. A graph may be attached.

_____
_____
_____
_____
_____
_____
_____

3. Have there been any SERs? If so, describe any plans. The SER Plan may be attached.

_____
_____
_____
_____
_____
_____
_____

Enhanced Supervision Plan
Monthly Review

4. Have there been any restraints? Discuss circumstances of restraint, the antecedents, and any plans by the team to reduce restraint based on this information.

5. Has there been a psychiatric consult? If so, discuss recommendations and any changes in medication or diagnosis.

6. Describe any changes in interventions during the period under review. Were any changes made to improve safety? Were any new positive interventions developed?

7. Was fading of the ES discussed during this review period? Were any actions taken or changes in the fading plan made? Note: When ES has been in place for 30 days, a fading plan must be submitted (See Attachment B).

Enhanced Supervision Plan
Monthly Review

8. Was the active treatment schedule changed? What actions were taken to improve the individual's quality of life?

9. Other:

QMRP Signature _____ Date of Review _____

BRC Representative _____ Date of Review _____

Clinical Director _____ Date of Review _____

Department of Health and Welfare
Idaho State School and Hospital
Nampa, Idaho

Operating Policy and Procedures

Subject: Guidelines for Behavioral Intervention		**ISSH Policy R.L. #3** Page 1 of 13
Effective date: August 9, 2006	**Supersedes:** R.L. #3 Dated 06/01/05	**Approved by:** SBloetje **Date:** 8/9/06

I. PURPOSE:

The following policy provides methods to increase desirable behavior and to decrease problem behavior. These methods serve as guidelines for the development of treatments so that exposure to intrusive procedures is minimized.

II. POLICY:

ISSH recognizes that the acquisition of positive behavior, provision of positive supports and person centered approaches are necessary to help an individual control and eliminate undesirable behavior and stabilize psychiatric disorders. The approach emphasizes the use of the least intrusive measures, that are likely to be effective, and that these measures will be used prior to more intrusive methods.

All programs aimed at reducing problem behaviors must include training for positive, adaptive behavior. The overall approach is person centered and the development of plans to address problem behavior should, whenever possible, involve the client, the parent/guardian, persons serving as advocates on behalf of the individual, and friends. ISSH is committed to the use of best practice procedures based on sound functional analysis and psychiatric assessment

Interventions recognized by ISSH are organized into four levels from least to most intrusive. Before using an intrusive procedure, staff will document that a less intrusive program was systematically tried and was demonstrated to be ineffective. However, in some situations, a more intrusive technique may be needed to provide adequate safety for the client or others. In cases where a less intrusive program is not used first, evidence will be given justifying the decision not to use a less intrusive, positive approach. In addition, a rationale should be provided to justify the use of the specific restrictive technique selected.

In regard to the use of psychotropic medication, it may be the case that, initially, the least intrusive, clinically appropriate intervention may be a pharmacological intervention.

However, the standard safety precautions should be applied and non-pharmacological active treatment should ideally occur concurrently or within a month of initiating the medication (*Pharmacological interventions: Safety precautions for persons with developmental disabilities*).

The facility approved hierarchy is organized from the least intrusive to the most intrusive procedures. Level I procedures require no formal programming or approval; Levels I-III require approval and are written programs.

Level I: No formal programming required
No approvals required
All staff may use

Level II: Formal written program required
Treatment team approval

Level III : Formal written program required
Treatment team approval
Behavior Review Committee approval
Human Rights Committee Review
Guardian consent required

Level IV: This level has the same requirements as level II but prior to the program going to HRC, the Clinical Director must approve the use of the procedure.

Level I:

These procedures may be used by staff at any time with no prior approval.

1. **Activity Restriction A:** Restriction of a person from participating in an activity while the person is in a highly agitated state (i.e., is engaging in dangerous or destructive behavior) or who has engaged in that type of behavior within 30 minutes of the activity and has not calmed resulting in a high risk of putting self or others at danger.

2. **Contingent Delivery of food items A:** This involves encouraging postponement of a food item at a meal; that is, the individual may be prompted to wait before taking the next bite if the individual engages in behavior that may put him/her at risk or is eating at a socially unacceptable pace (i.e., does not swallow between bites). For example, if the individual has difficulty swallowing, begins coughing or choking, the individual will be prompted (using no more than a verbal prompt alone or a verbal prompt paired with a touch cue) to delay the next bite of the meal until the individual swallows, finishes coughing or drinks some fluids.

3. **Environmental Engineering A:** Changes in the physical, programmatic, and interpersonal environment to better fit the person's characteristics and needs. This often includes restructuring environment to avoid known conflicts or problems from occurring. Examples: Keeping two clients from sitting together; turning down loud music that upsets some clients.

4. **Ignoring A:** Not attending to negative behaviors. Client is <u>not</u> in any distress or potentially harming others. Example: Ignoring a client that is playing with his pants zipper. This may take the form of ignoring the individual for the period during which the problem behavior occurs or attending to the individual while ignoring the problem behavior.

5. **Loss of personal property A** is the removal of property that is illegal or not consistent with policy (firearms, weapons, alcohol).

6. **Loss of personal property B** is the removal of personal property that is being used in a dangerous or unsafe manner. The item is put in a secure area and the QMRP or RN/AOD is notified immediately. The item may be withheld up to 72 hours pending approval and a team decision.

7. **Problem solving:** This is a strategy to help an individual develop an effective, appropriate and practical solution for a problem that has resulted or might result in challenging behavior. The process involves helping the individual identify their problem, generate several solutions and then evaluate each potential solution in terms of effectiveness and practicality to achieve a desired outcome.

8. **Positive Reinforcement**: This includes the use of praise, as a consequence for desirable behavior.

9. **Redirection/Distraction A**: This involves refocusing the attention of the individual away from one activity, location or behavior to another. Examples include: suggesting a new activity, or behavior; using humor or initiating discussion on a new topic; prompting to go to another location. Use of the prompt hierarchy up to full physical is acceptable as long as there is no resistance from the individual. When prompting to another area, assistance up to the level of an HIS escort is acceptable.

10. **Restitution A:** When a problem behavior has resulted in the environment being disturbed and the client is prompted to restore the environment to its condition before the behavior. Examples: Throwing an object would result in picking up the object and putting it where it belongs; if a client spills coffee, the client would be instructed to clean up the spill. Nothing other than a touch cue is required.

11. **Role Modeling:** Staff demonstrates or models for the individual the behavior that they would like the person to display. For example: standing an acceptable distance away from someone while talking to them and bringing the individual's attention to the distance; speaking in a soft voice and asking the person to say something at the same volume level.

12. **Star System:** This is a five (5) step process which provides staff with the tools to prompt individuals to make positive choices. Details of the Star System are included in the facility's HIS (Human Interaction System) manual.

13. **Tactical Mediation:** This is a technique that includes interpersonal communication strategies such as empathy, active listening and paraphrasing. The details of this technique are included in the facility's HIS manual.

Level II:

The treatment team will give approval of Level II programs.

1. **Behavioral Contracting** also called a contingency contract. The contract is a written agreement between two parties in which one or both parties agree to engage in specified behavior. The contract specifies that the consequence be administered on the occurrence or non occurrence of some behavior. The contract can involve the individual setting up goals to work on. The process involves some negotiation. Team staff agrees to provide supports and/or reinforcement for meeting the contingency. When a consensus is reached, all individuals sign the contract. Contracts have regular reviews.

2. **Behavioral Momentum:** This is an antecedent strategy used to decrease problematic escape behavior to requests by staff. The intervention involves giving instructions/requests prior to asking the individual to engage in a less preferred activity. The individual is reinforced for the easy requests and then the request to engage in the less preferred activity follows.

   An example for a person who is sometimes resistive to taking medication would be to first reinforce the individual for a greeting, shaking hands, throwing away an item or engaging in some helpful behavior. After being reinforced for these responses the individual is asked to take their medication.

3. **Behavioral skills training** is a group of procedures to teach skills that are not necessarily in the person's repertoire. The teaching techniques include modeling, instructions, rehearsal (practice), and feedback reinforcement and/or further instruction). Behavioral skills training is particularly suited for group instruction for social skills training, such as the acquisition of assertive behavior.

4. **Contingent Delivery of Food Items B:** This involves postponing a food item by blocking or prompting; that is, the individual may be prompted to wait or blocked from taking the next bite if the individual engages in behavior that may put him/her at risk. For example, if the individual has difficulty swallowing, begins coughing or choking, the individual will be prompted to pause before taking the next bite until the individual swallows, finishes coughing or drinks some fluids or drinks some fluids.

5. **Desensitization:** This is a fear reduction technique and is used is used primarily to treat fear of certain situations. The primary strategies are gradual exposure to fearful situations and response shaping.

6. **Differential Reinforcement** is a procedure to strengthen an appropriate behavior. The intent is for desirable behavior to receive a greater payoff than inappropriate behaviors. Thus reinforcement is minimized for problem behavior. To implement this procedure, the desirable behavior must be occurring at some level. The type of reinforcement is unlimited and includes such things as praise, desired activities, tokens, edibles, points, and other tangible items. A number of schedules of differential reinforcement have been identified in the literature:

    A. **Differential Reinforcement of Other Behavior (DRO)**: The absence of a problem behavior is reinforced at specified intervals. This schedule of reinforcement has several variations.

    B. **Differential Reinforcement of Incompatible Behaviors (DRI)**: The reinforcement of behavior that is incompatible (cannot occur at the same time) with a problem behavior.

    C. **Differential Reinforcement of Alternative Behavior (DRA):** Is the replacement of a problem behavior through the reinforcement of an alternative (appropriate) behavior. The alternative behavior does not necessarily have to be an incompatible response.

        1. DRA can be used to teach a **functionally equivalent replacement behavior.** This is a behavior that serves the same function as the problem behavior and is typically identified through Functional behavioral Assessment.

    D. **Differential Reinforcement of Communicative Behavior (DRC)** refers to the reinforcement of communicative responses that serve the same function as the problem behavior. This is also known as functional communication training.

1. **DRC** is also used to reinforce adaptive behavior that is not functionally equivalent but that is related to the problem behavior. Examples include coping skills, relaxation, self management skills, and social skills.

2. When the desired behavior is not in the person's repertoire, teaching must occur so that the behavior can be reinforced (see prompting and behavioral skills training).

7. **Extinction**: The removal of the reinforcer that maintains a problem behavior.

   A. **Ignoring B** is the removal of attention from a client when he/she is engaging in problem behavior. This method is used when attention is believed to be the maintaining variable. For example, a client screams to gain attention and staff turns away and ignores the client. Typically, no interaction will occur with the client while screaming is occurring. The team needs to make a decision on Level II ignoring (as opposed to Level I) when the client is in distress, engaging in disruptive behavior, or engaging in potentially serious behavior that does not actually result in harm (e.g., light hitting of self on the legs or mild property destruction such as tearing magazines).

   B. **Escape Extinction I:** Escape is prevented through environmental changes, verbal instructions, and prompting. This behavioral method is used when a problem behavior is used to escape demands, tasks, events, and people, etc.; it is typically part of an overall program of positive reinforcement.

8. **Prompting and reinforcement:** is a method to teach new adaptive responses. The technique involves the use of a graduated hierarchy of prompts from least to most intrusive that are designed to get a behavior or some approximation, to occur. When the response occurs, reinforcement is provided and over time the prompts are faded until the client engages in the repose to more natural cues.

9. **Response Cost A:** Also called bonus response cost. Response cost is removal of a reinforcer contingent upon some problem behavior. With this procedure the client does not lose points or tokens that they have already earned. There are several variations. One involves reinforcing some adaptive behavior and adding a bonus amount of reinforcement to it. The client is fined for problem behavior out of the bonus reinforcers.

   For example, an individual earns 30 points for room cleaning. An additional 50 points are added to this; during room cleaning the individual loses 10 points for rude behavior and swearing during room cleaning the response cost fines are removed from the 50 point bonus.

10. **Restitution/Restoration B**: This procedure is used when a problem behavior has resulted in the environment being disturbed and the client is prompted to restore the environment to its condition before the behavior. The prompt hierarchy, up to and including physical guidance, should be used. Examples: Throwing an object would result in picking up the object and putting it where it belongs; if a client spills coffee, the client would be instructed to clean up the spill.

11. **Satiation I**: This is a method of response suppression in which the reinforcers that maintain the problem behavior are given frequently and in such quantities that the individual becomes sated. For example, providing free popcorn to reduce pica that is thought to be a function of hunger. Giving copious amounts of attention to reduce attention-maintained problem behavior is another example.

12. **Self Management Training:** This involves teaching the client increased self control and self-awareness. It often involves teaching self-monitoring, setting goals, self evaluation, self instruction, and self-reinforcement.

13. **Setting events (establishing operations):** These are defined as a change in the environment that alters the value of different activities, reinforcers, and behaviors. Setting events (SE) can be used in a variety of ways to decrease problem behavior or assist in teaching positive behavior.

    A. Minimizing setting events: For example, when decreased sleep might be a setting event correlated with problem behavior. Minimizing this SE would include efforts to improve sleep, provide naps, etc.
    B. Neutralizing SEs is a strategy used when the SE cannot be removed or minimized. An example is providing a schedule and reminders of upcoming activities when transitions have been identified as related to problem behavior.
    C. Interrupting response chains is a strategy utilizing a setting event approach. By stopping ball play with an individual, the value of a communicative response, such as a request, is momentarily changed thus providing a teaching opportunity.

14. **Shaping** is the differential reinforcement of successive approximations of a target behavior until the final desired response is in the person's repertoire. Shaping is often used to teach new behaviors as well as to increase existing behaviors that may be challenging for the individual by evoking escape behavior.

15. **Stimulus Control:** In certain contexts positive and problem behavior are more likely to occur. When functional assessment identifies these situations, they can be used to maximize the occurrence of positive behavior and minimize the occurrence of problem behavior.

Level III:

Level III programs require approval from the Human Rights Committee and consent from the parent/guardian before implementation.

1. **Body Search A**: Client is dressed and searched by staff or detection device. All programmatically prohibited items will be removed (see Level III, non-contingent removal of items).

2. **Contingent Delivery of food items C**: This involves limiting immediate access to a full meal by presenting food and/or drink in small portions at a time (i.e., one or two bites of food, a swallow or two of liquid in a glass). However, the full contents of meal are always presented during the course of the meal time. This technique is used only when an individual has not developed the ability to eat at a safe pace and has documented swallowing problems or a history of choking or at a health risk for eating too rapidly.

3. **Contingent loss of personal property**: The removal of personal property contingent upon the occurrence of a target behavior is not to exceed 24 hours. The item(s) are held in a secure area and returned to the individual at the end of the specified interval. Positive procedures must be in place that is designed to reduce the need for this type of intervention.

4. **Enhanced Supervision:** In order to ensure client safety it is sometimes required to provide enhanced supervision. RL# 35 details different levels of supervision to with a hierarchy from least to most intrusive:

   General Supervision, Heightened supervision, Close proximity, and Arm's length supervision. Arm's length and close proximity require team and administrative approval as well as periodic administrative review.

5. **Environmental Engineering B:** This procedure includes the use of any devices in a client bedroom used to notify staff of client movement, distress, or need for assistance. Examples might include: Door alarms, motion detectors, chimes, buzzers, and visual notification (such as flashing lights).

6. **Escape Extinction B**: It may be a Level II procedure if it involves physical restraint or full physical guidance to prevent escape. These procedures are used when the client cannot be prevented from escaping with normal prompting strategies and is resistive.

For example, a client emits a problem behavior during a task. The staff would continue to prompt the client, using full manual guidance as necessary (for a specified interval or number of responses), to complete more of the task and then permit escape (break) contingent upon emitting an appropriate communicative response.

7. **Exclusionary Time-Out A:** Time-out is a procedure where an individual does not receive reinforcement for a specified period of time contingent on an identified behavior. This involves removing the individual from ongoing activity and/or persons to another area (e.g., hallway), part of a room, or to another room. Graduated prompting and assistance up to and including an HIS escort may be used. By definition, Time-out I means egress from the time-out area is not prevented. However, if the person leaves the designated time-out area and resumes the target behavior, he/she may be directed back.

   A. Exclusionary time-out programs must specify the following criteria:
      1. Target behavior(s) and replacement behavior(s).
      2. Method of escort to the time-out area.
      3. The data to be collected.
      4. Instructions for continuous observation.
      5. The criteria for ending time-out, returning to the activity, and resuming reinforcement. The time-out cannot exceed 60 minutes.

8. **Mechanical Restraint:** Application of any device to contain or restrain movement contingent upon a problem behavior or antecedents to that behavior. Mechanical restraint may also be used non-contingently (see RL #1). Types of approved mechanical restraints: Helmet, mitts, gloves, arm splints, cuffs (non-metallic), waist wrist restraint, locked belts, irremovable modified clothing, restraint belts, Velcro, partial or full body raps, partial or full body restraint board or chairs.

9. **Medication used for behavioral and psychiatric conditions**: The use of a psychotropic medication to manage behavior or psychiatric symptoms on either an emergency or long term basis.

10. **Medication used for sedation during medical treatment or procedures:** Administration of psychotropic medication to facilitate the safe provision of periodic or routine medical care and treatment when the person's behavior is uncontrollable by other less intrusive methods See Medical #34 – Medical Restraint.

11. **Nitrous Oxide:** Nitrous oxide is administered and monitored by the dentist to induce relaxation during dental exams and treatment. It is used with individuals who have a history of anxiety associated with dental care, or refusal and resistiveness. See ISSH Policy Medical # 7 – Nitrous Oxide.

12. **Non-contingent Removal of Items**: Removal of items for therapeutic reasons, certain items may not be allowed in the possession of clients. Some examples are, but not limited to: Items that can be used as weapons or for self-injury, children's pictures, pornography, R-rated or higher videos, children's videos, chemicals, alcohol and tobacco product items, matches and lighters.

13. **Physical Restraint**: Body to body contact to contain/restrain movement contingent upon exhibition of maladaptive behavior or antecedents to that behavior. Restraint may also be administered non-contingently (that is, when restraint is applied prior to a behavior occurring in order to prevent injury). These are limited to facility approved techniques.

14. **Response Cost B:** This is defined as removal of a reinforcer contingent upon a maladaptive behavior. The reinforcers removed are points, tokens, or opportunities to spend such for an identified time. This also includes the loss of an item for a specified period of time. This is an intrusive procedure when the individual is fined tokens that have already been earned for some other behavior. Example: Client is assaultive and loses 5 points or the opportunity to exchange points for 1 hour. No personal possessions can be part of response cost at this level; only tokens and other reinforcers provided by the facility can be used.

15. **Restriction of access to areas on or off campus:** restriction is usually for concerns of client safety or safety for others. When the restriction is intended to be temporary, the plan must provide the length of time the teams believes will be necessary. A review by HRC should occur if the team intends to go beyond this date. Often more permanent restrictions are used for individuals who pose a risk to others because of a history of sexual offenses. The program must specify those areas/activities to be restricted and identify ample access to activities in the community that are appropriate for the individual.

16. **Room Search A**: An individual's room is searched to determine the present of items that have been prohibited through an approved BSP. The individual is afforded the opportunity to be present and all programmatically prohibited items will be removed (See non-contingent removal of items). There must be a second staff person present during the search as a witness.

17. **Satiation II**: When the reinforcing event is an action by the person, the strategy involves the repetition of the action until fatigue or boredom set in. The procedure is usually continued until the individual rejects the activity or attempts to escape it. Thus, the activity is continued until it behavior is no longer reinforcing to the individual. This procedure must be used in conjunction with other positive procedures.

Level IV:

1. **Body Search B**: Client is strip-searched and body cavities are examined and the client does not consent to the search. All contraband or inappropriate items will be confiscated.

2. **Environmental Engineering III**: Any modification that inhibits usage or placement of normal household items. Some examples include, but are not limited to, window bars, cranks removed, and toilet and faucet modifications, bolted down furniture, removing furniture, plexi-glass covering to prevent window access or egress.

3. **Escape Extinction III**: This differs from Escape Extinction II in that it involves physical restraint, full physical guidance, or mechanical restraint to prevent escape. These procedures are used when the client cannot be prevented from escaping with normal prompting strategies and is resistive.

    A. For example, a client emits a problem behavior during a task. The staff would continue to prompt the client, using full manual guidance as necessary (for a specified interval or number of responses), to complete more of the task and then permit escape (break) contingent upon emitting an appropriate communicative response.

4. **Exclusionary Time-out B:** The Time-out II procedure involves removing an individual from ongoing activities, milieu and reinforcement to a designated area or room from which egress is prevented. The five criteria listed in exclusionary Time-out I procedures must be outlined in the program. In addition, the following criteria must be met:

    A. The bedroom(s) must not be used unless specifically identified as a time-out area in the program.
    B. When bedrooms are used, and the door is closed, an observation window must be built in the door. During the time-out procedure, the client must be visible at all times through the window while in the bedroom.
    C. Staff must not hold the door shut unless it is fitted with a mechanism requiring constant physical pressure from a staff member. The door may not open inward.
    D. The completion of a functional assessment must be documented prior to the implementation of any time-out program.
    E. The program will include instructions to staff to immediately discontinue the time-out and intervene if it is observed that the client is incontinent, ill, or in danger of harm.
    F. Time-out rooms shall be free of hazardous conditions.

5. **Overcorrection**: Is a procedure used to reduce the occurrence of an inappropriate behavior. The individual is required to engage in effortful behavior contingent upon the problem behavior. There are two types: Positive Practice and Restitution.

   A. **Overcorrection/Positive Practice:** The client is required to engage in correct forms of a behavior following a problem behavior. For example, a child who puts some gum on a desk would practice throwing gum into the garbage repeatedly. Or a student who rushes and misspells words would be required to write the words correctly 20 times each.

   B. **Overcorrection/Restitution:** The client must restore or correct an environment he has disturbed to its condition before the occurrence. The client must then improve it beyond its original condition, thereby overcorrecting the environment. For example, an individual writes on a wall and is required to clean the wall that was written on and, in addition, is required to clean the other walls in the room.

6. **Room Search B**: Individual does not have to be present and does not need to consent to the search. There must be a second staff person present during the search as a witness. All programmatically prohibited items will be removed (See non-contingent removal of items).

7. **Tracking Devices**: Arm bands, belts, or ankle bands that emit a tracking signal and are not removable by the client.

III. OTHER INTERVENTIONS:

As a general rule, the only interventions to be used at the facility are those listed above. On rare occasions, an intervention may be necessary other than one outlined above. This intervention must be reviewed by the Clinical Director or designee prior to inclusion in a program. If the intervention is recommended for more than one individual, it must be presented to the HRC members, the Clinician PPG (Professional Practice Group), and the Clinical Director for approval and addition to this policy.

Additional procedures that are restrictive in nature but are required by outside programs or facilities, such as by the court, will be incorporated into the individual's IPP according to this policy.

VI. PROHIBITIONS:

The use of seclusion, corporal punishment, abusive practices., denial of water, adequate nutrition, or discipline by other residents are prohibited and may not be used to manage or modify client behavior.

VII. PROCEDURES:

1. The Treatment Team will have final authority for approving Level II programs and will review these programs at least annually.
2. After the Treatment Team has approved all Level III and Level IV programs, they are forwarded to the Behavior Review Committee (BRC) for review and approval.
3. The programs approved by BRC are then forwarded to the Human Rights Committee (HRC) for review prior to obtaining informed consent.
   a. These programs will be reviewed by HRC at least annually as part of the PCP process or when changes occur that make the program more intrusive.
4. Level IV programs must have Clinical Director approval prior going to HRC.
5. Client, parent or guardian consents for Level III and Level IV programs will be obtained prior to implementation.
6. Standing or 'as needed' programs are not permitted.

References: ICF/MR Regulations W266 through W296; ISSH Policies: Med. #34 – Medical Restraint; Med. #7 – Nitrous Oxide R.L. #1 – Behavioral Restraints; R.L. #35 – Enhanced Supervision

REVIEW: Human Rights Committee; Clinicians
Required Reviews/Approvals: Policy Review Committee; Clinical Director; Administrative Director
Review Date: 07/06 **Next Review Date:** 08/09
Originator/Date: G. Tidwell 2/05

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

Sue Broetje – Administrative Director
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1660 11TH Avenue North
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August 29, 2006

Debra Ransom, Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705

RE: Notice of Intent to Appeal

Dear Ms. Ransom:

This letter is notice that the Idaho State School and Hospital intends to appeal the Bureau of Facility Standards' probable decision regarding the non-renewal of its ICF/MR provider agreement.

Preliminary information from the survey exit yesterday indicated that the facility failed to meet certain conditions of participation. We have been informed that it will take approximately two weeks to complete the findings from the survey. When the Idaho State School and Hospital receives official notification of the survey results, it will appeal that official decision.

Thank you for your assistance.

Sincerely,

SBroetje

SUSAN BROETJE
Administrative Director
Idaho State School and Hospital

Cc Randy May
Michelle Britton
Sherri Kovach
Melissa Vandenberg

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
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August 30, 2006

FILE COPY

Susan Broetje
Idaho State School And Hospital
3100 Eleventh Ave North
Nampa, ID 83686

Dear Ms. Broetje:

On June 19, 2006, a complaint investigation survey was conducted at Idaho State School And Hospital. The survey was conducted by:
Michael Case, Social Worker/qmrp
Sherri Case, Social Worker/qmrp
Nicole Wisenor, Human Srv Prof/qmrp
Monica Williams, Human Srv Prof/qmrp
Lea Stoltz, Human Srv Prof/qmrp
Lois Hollingsworth, Registered Nurse
Sylvia Creswell, Social Worker/qmrp.
This report outlines the findings of our investigation.

Complaint # ID00001434

Allegation: Individuals designated as 1:1 are not recieving adequate supervision.

Findings: An on-site complaint investigation was conducted from 5/15/06 - 6/19/06. Observation, record reviews, and interviews were conducted.

The facility's Significant Event Reports and Investigations were reviewed. The investigations included two reports from Pine Group 1, dated 4/28/06 and 4/29/06. The reports stated that while investigating client to client assaults, potential negligence was identified as follows:

a. An investigation, dated 04/28/06, stated two individuals residing on Pine Group 1 were involved in an altercation in the dining area of the unit.

One of the individuals was assigned 1:1 staff who had stepped away from the area, leaving the individuals unsupervised.
The altercation resulted in scratches and "open areas" for both individuals, and bite marks on one individual. The accused staff admitted to the investigators she had failed to maintain 1:1 supervision as directed in the individual's plan.

b. An investigation, dated 04/29/06, stated two individuals residing on Pine Group 1 were involved in an altercation in the day hall of the unit. One of the individuals was assigned 1:1 staff who had stepped away from the area, leaving the individuals unsupervised. The altercation resulted in bite marks and bruising on both individuals. The accused staff admitted to the investigators he had failed to maintain 1:1 supervision as directed in the individual's plan.

Both investigations substantiated that neglect had occurred due to a lack of appropriate supervision for the individual who was to receive 1:1 supervision. It was further determined that the staff responsible for 1:1 supervision on both occasions were "borrowed" staff, who were unclear as to the implementation of 1:1 supervision for the individual.

As both incidents involved the same two individuals and similar circumstances, and the outcome of the investigations was the same, the facility's corrective action was as follows:

- Staff responsible for 1:1 supervision in the incidents were counseled individually regarding the facility's expectation for 1:1 supervision of individuals.

- Training was provided to all staff on the unit regarding 1:1 supervision expectations for those individuals who had 1:1 supervision requirements.

- Supervisory and professional staff were counseled regarding assignments of 1:1 staff to assure proper training of expectations before undertaking 1:1 supervision duties.

The facility failed to assure 1:1 supervision was conducted, as outlined in the facility's policy, for an individual who had 1:1 supervision deemed necessary. This failure resulted in altercations taking place between the same two individuals residing on Pine Group 1 on two consecutive days. Both altercations resulted in injury to the individuals, and were directly related to the failure to maintain 1:1 supervision as needed.

Conclusion: While the incidents did occur, the facility took appropriate action and no deficient practices were identified related to the investigation reports dated 4/28/06 and 4/29/06. However, other incidents of individuals not receiving adequate staff supervision were identified on the Pine Group 1 unit. The lack of sufficient staff supervision and intervention placed the individuals in serious and immediate jeopardy and deficient practices were identified. Therefore, the allegation is substantiated.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208)334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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FILE COPY

August 30, 2006

Susan Broetje
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Dear Ms. Broetje:

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Lea Stoltz, Human Srv Prof/qmrp
Lois Hollingsworth, Registered Nurse
Sylvia Creswell, Social Worker/qmrp.
This report outlines the findings of our investigation.

Complaint # ID00001345

Allegations: An individual was subjected to improper use of mechanical restraints that resulted in him being physically harmed.

Findings: An on-site complaint investigation was conducted from 5/15/06 - 6/19/06. Observations, record reviews, and staff interviews were conducted.

The facility's Significant Event Reports were reviewed and included documentation of injuries associated with mechanical restraints placed on an individual on 4/28/06 at 12:40 p.m. The attached investigation report stated "during the restraint the staff attempted to place the mechanical restraint, during the process the belt became twisted on (individual's name) waist causing a potential air restriction and resulting in the cuff portion of the belt to be off alignment..."

The individual's behavior support plan, dated 4/6/06, stated the plan was being revised to incorporate the use of mechanical restraints. The attached picture and description of the mechanical restraints included ankle and wrist cuffs. However, the belt that the wrist cuffs attached to was not shown.

When asked about the belt, the QMRP stated during an interview on 6/16/06 at 8:02 a.m., the belt was included in the information that was discussed with the individual's guardian via the telephone. However, the wrong picture of the restraints (which did not include the belt) was placed in the program and sent to his guardian for written approval. The QMRP further stated the use of the belt was discontinued due to injuries. The QMRP who assisted on the unit also stated the picture of the restraint attached to the individual's behavior plan was reflective of the mechanical restraints currently being used for the individual (i.e., without a belt).

Conclusion: Due to lack of sufficient evidence, it could not be substantiated that the individual was subjected to unauthorized use of mechanical restraints (i.e., the belt). Additionally, while he did sustain injuries associated with the use of the belt, the facility took appropriate corrective action in discontinuing its use.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 25, 2006

Debbie Ransom, R.N. R.H.I.T.
Bureau Chief
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RE: Idaho State School and Hospital, Provider #13G001

Dear Ms. Ransom:

Please consider this letter and the information attached to be a credible allegation that the Idaho State School and Hospital has implemented changes and provided training which correct the concerns identified as a Serious and Immediate Jeopardy by the survey team on August 24, 2006.

On August 22, 2006 a change was implemented that a room search was to be conducted every time there was a change in staff supervision (approximately every two hours.) This was initiated at 10 a.m. on 8/22 and continued until she was hospitalized for an unrelated condition.

Additionally, room modifications have been made which remove sharp edges and medal pieces that she could use for self-injury, modifications were made to her enhanced supervision guidelines, and clothing/body searches were added after high risk times with accompanying documentation. The specifics of these changes are included in the attached documentation.

We are confident that these changes significantly reduce the risk to this client's ability to self-injury and remove the imminent risk that was identified. If you have any further questions, please feel free to contact me.

Sincerely,

SBroetje

Susan Broetje
Administrative Director

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W127 and W149.	MM177		
MM182	16.03.11.075.09 (a)(iv) Resident placed in Restraints The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and This Rule is not met as evidenced by: Refer to W303.	MM182		
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the	MM191		

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MM191	Continued From page 1 patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W295 and W297.	MM191		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197		
MM211	16.03.11.075.17 Right to Appropriate Treatment Right to Appropriate Treatment, Services, and Habilitation. Residents have a right to appropriate treatment, services, and habilitation. This Rule is not met as evidenced by: Refer to W154.	MM211		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and	MM212		

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MM212	Continued From page 2 This Rule is not met as evidenced by: Refer to W126, W195, W196, W249, W250, and W266.	MM212		
MM336	16.03.11.110.04(b) Emergency Plans Emergency plans must be thoroughly tested and used as necessary to assure rapid and efficient function. This Rule is not met as evidenced by: Refer to W449.	MM336		
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W441.	MM337		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building and all equipment were in good repair and kept clean and sanitary for 91 of 91	MM380		

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MM380	Continued From page 3 individuals (Individuals #1 - #91) residing in the facility. The findings include: 1. During environmental observation of the Birch 1 Unit on 6/15/06, from 1:50 p.m. - 2:50 p.m., the following issues were noted. Room #151 - The bedroom was in need of cleaning and organization. Room #155 -The bedroom was in need of cleaning and organization. Room #159 -The bedroom was in need of organization. There were 4 suitcases on the floor in the bathroom, which needed to be stored elsewhere. The 2nd drawer front of the dresser was broken. Room #161 - The bed was not made. The room was in need of painting due to large patched areas. Room #163 -The closet had linen spilling out of it. The contents of storage cubes had spilling out onto the floor. There was laundry stacked on the counter in the bathroom. Room #167 -There was dirty laundry on the floor. The bed was not made. 2. During environmental observation of the Birch 2 Unit on 6/15/06, from 2:50 p.m. - 3:30 p.m., the following issues were noted. Room #192	MM380		

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MM380	Continued From page 4 There were 3 overflowing containers of what appeared to be dirty clothing. Room #200 -The bedroom was in need of organization. There was not enough storage for the crafts, stuffed animals, etc. that were laying about on the floor. There were dirty clothes laying on the floor in the bathroom. Room #194 -The bedroom did not have enough storage to contain the items laying about on the floor. Coffee and sugar were stored on a shelf in the bathroom, an alternative storage area was needed. A cardboard box was being utilized as a garbage container in the bathroom, which created a fire hazard. Staff accompanying the surveyor was immediately apprised that the box need to be removed. Room #184 -The bed had not been made. Room #186 -The second drawer of the dresser was broken. Room #182 -The bed had not been made. Shoes were laying on the floor surrounding a shoe rack, additional storage was needed. A cover was needed for the electrical cords from the TV, VCR, clock, and C-Pap machine. Room #198 -The bolt of the entrance door scraped on the striker plate. The individual residing in the room asked that it be fixed. 3. An environmental survey of the Aspen unit was	MM380		

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MM380	Continued From page 5 conducted on 6/14/06 at 11:20 a.m., and showed the following concerns: Aspen 1: Laundry Room: - Two laundry hampers were dirty with dust. - The floor next to the baseboard was dirty with sunflower seed shells and dust. Dining Area/Kitchen: - There was what appeared to be spilled pepper in the towel drawer. - The microwave had food splatters on the top and bottom. - The range had aluminum foil in the bottom of it with burned on food. - A griddle had burned on grease on it, an uncleanable surface. - Two cake pans and a cookie sheet had burned on grease on them. Game Area: - The mid-high wall near the display case had a circular black mark. The display case needed to be cleaned as it had what appeared to be food stains on it. Aspen 1 and 2: All the Individuals' rooms needed to be cleaned and organized due to unmade beds, clothing on the floor, the desks cluttered with radios, CD players, tapes, CDs, and miscellaneous items. The bathroom counters were cluttered with toothpaste, toiletry items, cups, shampoo, etc. The refrigerators in their rooms had food spillage and needed to be defrosted. The wooden shelves in the bedrooms had a layer of dust on them. 4. During environmental observation of the Pine I Unit on 6/14/06 at 1:10 p.m., the following	MM380		

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MM380	Continued From page 6 cleanliness and maintenance issues were noted. Dayroom: - The plaster under the window in the dayroom was peeled/missing, the size was approximately 2 by 3 inches. - The wall between the dayroom and hallway was marred and needed cleaning. - The floor of the dayroom was gouged and marred. - A half eaten sandwich was found in a drawer. - There was a 12 by 12 inch hole in the hallway near the baseboard Kitchen: - The refrigerator door did not seal, the temperature did not register and the service light was on. - The small upper cupboard door did not stay shut. - The microwave had food spills, the top was dented, and a leg was missing causing it to wobble. - The cupboard above the toaster had food crumbs and was in need of cleaning. - The cupboard below the stove top had food spills and needed cleaning. - The top of the dishwasher, and the inner edge of the door, had food stains, dried food and needed to be cleaned. - The cupboard under hand sink and cupboard beside dishwasher with chemicals had spills that were sticky and needed to be cleaned. Laundry room: - There was a large amounts of lint wadded and thrown behind the dryers and in the upper cupboard across from the dryers. - There was a build up of soap and lint around the interior dryer vents.	MM380		

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MM380	Continued From page 7 Dining area: - The top of the round table was scratched and marred exposing bare wood. - The seats and backs of the tall black chairs were cracked and frayed. Patio: - There was uncovered piping emerging from the ground in a planter on the patio, presenting a trip hazard. - There was debris including Styrofoam cups, paper plates and cups, plastic spoons, markers that were scattered around the patio and planters. - A wet bedspread was sitting on the patio. - The picnic table seats were cracked with paint chipped and peeling, and the top was marred. Room # 146: - The paint on the outer window frame of the window looking into the dayroom was chipped and peeling. - The room had a foul odor. - There was spilled milk, food remains, and pop can remains on the shelf under the TV. - The upholstery was stained, and there was trash/food items in the chair cushions. - Their was soiled rubber gloves sitting on a chair. - The door to the TV cabinet was missing, and the wood was chipped around the screw holes for hinges leaving exposed particle board. Room #151: - The dresser bottom drawer was broken and the front panel was missing. - The shelves under the TV were unfinished. - There was a urine hat in the toilet filled with urine. Room #153:	MM380		

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MM380	Continued From page 8 - There were multiple gouges/scrapes on the walls, the finish was gone and they were in need of patching and paint. - There was red and blue marker all over the walls by the bed. - There was unfinished wood exposed on the back of the TV cabinet. - The shower curtain was soiled with soap scum and other unidentifiable substance and needed cleaning. - There was tooth paste on the top of the door frame and on the bedroom wall across from the bathroom (about 7 ' up from the floor). - There was apple juice splashed on the walls in multiple locations. - The pillows did not have pillow cases. Room #155: - The walls were soiled and in need of cleaning and paint. - The shower was soiled and in need of cleaning. - There was a toilet brush lying on the floor under the counter. - There were no pillow cases on the pillows. - The sheets were soiled. Room #157: - There was a hole in the wall by the bathroom door approximately 6 by 6 inches. - The paint on the door frame was scrapped off, exposing metal. - The shower was soiled with soap scum and needed cleaning. - The walls in the bathroom were gouged and had large cuts in the plaster. - The flooring in the bathroom was gouged and had holes torn in the vinyl. - The frame between the windows was dented, had broken plaster, and had exposed metal from the wall.	MM380		

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MM380	Continued From page 9 - There was partially eaten food items on the desk and shelving. - There was a foul odor in the room. - The sheets were soiled with body fluids and unidentifiable stains. - There were no pillow cases on the pillows. - There were empty soda cans and spilled liquids of unknown origins on the shelves. - Two of the shelf on the book shelf unit were missing the front edges exposing unfinished wood surfaces. Room #159: - There were wet, soiled towels piled on the floor. - The grooming kit was soiled and needed cleaning. - The shower curtain was soiled with soap scum and unidentifiable stains. - The bed sheets were soiled with unidentifiable stains. - The walls and light fixtures were soiled with unidentifiable stains. Room #161: - There was a foul odor in the room. - The shower curtain was soiled with soap scum and unidentifiable stains. - The shower stall was soiled with mold and soap scum. - The grooming kit contained spills and needed cleaning. - The walls were soiled with unidentifiable stains, and had chipped plaster. Room #163: - There was a hole in the wall behind the door where the door handle had been pushed through the plaster. - The bed sheets were soiled with unidentifiable stains.	MM380		

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MM380	Continued From page 10 - The shower was soiled with mold and soap scum. - The shower faucet was leaking. - The bathroom walls had various stains of unknown origin. Room #165: - The room was being remodeled but contained clients personal possessions in boxes scattered across the floor creating a trip hazard. Room #169: - The bed sheets were soiled with bodily fluids and unknown substances. - The paint on the wall around the top of the shower was cracked and peeling. A busted up cabinet door was sitting on a shelf in the linen closet at end of the hall by Room #151 The double doors leading to Pine I at both entrances were marred at the bottom and up the center, and paint was missing exposing unfinished metal. During environmental observation on the E Unit, on 06/14/06 at 2:48 p.m., the following cleanliness and maintenance issues were noted. Room E-06: - There phone jack by the door was missing a cover and had exposed wires. - The tile was separating by the wall and across the floor, and some of the tile edges were chipped and cracked. - The slats on the window blinds were folded back and bent. - There were four large screw holes in the wall above the second bed, and the plaster and paint around the holes was peeling.	MM380		

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MM380	Continued From page 11 - The cabinet in the closet had a hole punched through the door, and the kick board was missing exposing raw wood at the base of the cabinet. - There was a hole through the plaster approximately 1 inch by 2 inches, above the baseboard by the third bed. - A buildup of grime of unknown origins was found in the tile grooves in the bathroom flooring. Room E-41: - The air vent in the ceiling was layered in dust and lint. During environmental observation on the B Unit, on 6/14/06 at 3:40 p.m., the following cleanliness and maintenance issues were noted: - Various debris were found on the floor by the sink, including a pencil, a piece of rope, and a medication tube. - The tile base-board to the right of the sink cabinet was cracked and soiled. During environmental observation on the C Unit, on 6/14/06 at 3:55 p.m., the following cleanliness and maintenance issues were noted: - The refrigerator used to store client foods had an open, uncovered, undated can of applesauce sitting on the top shelf. - The freezer door inside the refrigerator used to store client foods would not latch. The temperature in the freezer was 19 degrees. During environmental observation on the S Unit, on 6/14/06 at 4:06 p.m., the following cleanliness and maintenance issues were noted: Day room: - The refrigerator used to store client foods was	MM380		

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MM380	Continued From page 12 missing the bottom drawer, and there were multiple food spills. Room D-23: - There were wet, soiled towels piled on the floor. Room D-27: - The shower curtain in the bathroom was soiled across the bottom with soap scum. Kitchen: - There was a build up of grime, soap, and food around the door frame and heating element of the dishwasher. Room D-36: - The mounting along the top of the dresser against the wall was broken exposing metal staples. - The box-spring on the bed was broken down and sagging, and needed to be replaced. - The walls had been patched, but needed painting to seal the surface for cleaning. - The door frame between the bedroom and bathroom was rusted at the base by the floor. - The window was missing the glass panes and was covered with plywood. Laundry Room: - There was a buildup of soap scum and soil on the washer door seal and the soap dispenser. - The dryer exhaust hoses were disconnected and lying on the floor behind the dryers. Room D-10: - The shower temperature was 72.1 degrees. - There was a large amount of fecal matter smeared on the toilet seat. During environmental observation on R Unit, on	MM380		

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MM380	Continued From page 13 6/15/06 at 1:15 p.m., the following cleanliness and maintenance issues were noted: Pod 171: - The mattress in Room 155 did not fit the bed and was hanging over the foot board. - The drapes in Room 155 were torn and frayed. - There were no screens on the windows in Room 155. - A 2 by 4 inch piece of wood, approximately 8 feet long, placed along the baseboard between the bed and the wall, was unpainted and unfinished and not a cleanable surface. - The upper walls in Room 152 were unfinished, unpainted drywall, and were not a cleanable surface. - The drapes in Room 150 were torn and frayed. - The windows in Room 150 did not have screens. -The windows in Room 153 did not have screens. - The upper walls in Room 153 were unfinished, unpainted drywall and were not a cleanable surface. - There was an open, half filled soda can sitting on the shelf in the day room. - The freezer temperature was 30 degrees, and the door was not closed properly. - The refrigerator contained open food containers that were not dated. - There were scoops left in the coffee containers. - The paint on the cabinet in the bathroom was peeled and chipped. Pod 172: - The walls in Room 132 were scuffed and patched, and needed paint to provide a cleanable surface. - The dresser drawers in Room 134 were open with clothing hanging out and on the floor. - There was no mattress pad or bottom sheet on	MM380		

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	13G001	A. BUILDING _____ B. WING _____	C 06/19/2006

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MM380	Continued From page 14 the bed in Room 134. - There were no pillow cases on the pillows in Room 134. - The microwave had food spills and splatters on the interior walls, bottom, and top. - The coffee containers had scoops left inside. -The molding around the outside of the dishwasher was missing, and the exposed area was soiled with spilled food. - The sink was soiled with food particles and needed cleaning. - There were dishes soiled with half eaten food sitting in the sinks. - The temperature of the freezer was 16 degrees. Pod 173: - There was exposed, unfinished wood on the back of the headboard, which was turned towards the door, in the first bedroom to the left. - The mattress was hanging over the foot board in the second bedroom from the left. - The curtains were pulled from the window and laying on the floor in the forth bedroom from the left. - The headboard was pulled away from the bed exposing screws in the forth bedroom from the left. - There was spilled coffee grounds in the cabinet above the microwave. - The dishwasher had food spills built up along the door frame. - The temperature of the refrigerator was 52 degrees. - The temperature of the freezer was 8 degrees. - There were open food containers in the refrigerator that were not dated. - The cover to the dishwasher exhaust/overflow valve on top of the sink was missing. - There was a cloth linen hamper in the dining area that contained wet, soiled towels, and they	MM380		

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MM380	Continued From page 15 were leaking through the hamper bag. - The unit had a foul odor. Pod 174: - There was an open soda can in the upper right kitchen cupboard. - There was a scoop in the coffee container. - There was an open, unsealed bag of chips sitting in the cupboard to the left of the coffee pot. - There was a chain connecting the drain to the sink that had a plastic cover which was chipped and cracked, and the chain was rusted and moldy. - There were dishes with food sitting in the sink. - The cabinet in the dining area by the door contained open food containers that were not dated. - The closet door in Room 120 would not stay latched closed. - The paint around the electrical conduit by the windows in room 120 was cracked and peeling. At 2:40 p.m. the freezer temperature in pod 171 was reported to the QMRP. At 3:05 p.m. the QMRP reported the freezer temperature on Pod 171 was down to 5 degrees.	MM380		
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W482.	MM429		
MM512	16.03.11.200 Administration	MM512		

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MM512	Continued From page 16 The administration of ICF/MR facilities must provide for individual program planning, implementation and evaluation. Individual programs must be based on relevant assessment of needs and problems and must reflect the participation of the individual, the service providers, and where possible, the individual's family or surrogate. Individual program planning must include provisions for total program coordination and continuous, self-correcting processes for review and program revision. Programming for individuals must incorporate the resident's legal rights of due process, appropriate care, training and treatment. This Rule is not met as evidenced by: Refer to W100.	MM512		
MM513	16.03.11.200.01 Governing Body Each facility will be organized and administered under one authority which may be a proprietorship, partnership, association, corporation, or governmental unit. If administered by other than a single owner or partnership, the facility will have a governing board which assumes full legal responsibility for the overall conduct of the facility and for full compliance with these rules. This Rule is not met as evidenced by: Refer to W102 and W104.	MM513		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must	MM520		

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MM520	Continued From page 17 see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W277.	MM520		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W214.	MM724		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by:	MM729		

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MM729	Continued From page 18 Refer to W312.	MM729		
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W237.	MM731		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		
MM782	16.03.11.270.04(a)(i) Extraoral and Intraoral Examination A complete extraoral and intraoral examination must be performed, utilizing all diagnostic aids necessary to properly evaluate the resident's oral condition. This Rule is not met as evidenced by: Refer to W356.	MM782		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and	MM855		

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MM855	Continued From page 19 habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855		
MM860	16.03.11.270.08(f)(ii) Recording Progress Recording each resident's progress; and This Rule is not met as evidenced by: Refer to W252.	MM860		
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W255 and W260.	MM861		